Missouri

UNIFORM APPLICATION
FY 2024/2025 Combined MHBGSUPTRS BG ApplicationBehavioral Health Assessment and Plan

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 04/19/2021 - Expires 04/30/2024
(generated on 09/05/2023 12.08.19 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year	2024
End Year	2025

State SAPT Unique Entity Identification

Unique Entity ID	QLUAWH28TG83

I. State Agency to be the SAPT Grantee for the Block Grant

Agency Name	Missouri Department of Mental Health
Organizational Unit	Division of Behavioral Health
Mailing Address	PO Box 687
City	Jefferson City
Zip Code	65102-0687

II. Contact Person for the SAPT Grantee of the Block Grant

First Name	Nora
Last Name	Bock
Agency Name	Missouri Department of Mental Health
Mailing Address	PO Box 687
City	Jefferson City
Zip Code	65102-0687
Telephone	573-751-9499
Fax	573-751-7814
Email Address	nora.bock@dmh.mo.gov

State CMHS Unique Entity Identification

Unique Entity ID	QLUAWH28TG83

I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name	Missouri Department of Mental Health
Organizational Unit	Division of Behavioral Health
Mailing Address	P.O. Box 687
City	Jefferson City
Zip Code	65102-0687

II. Contact Person for the CMHS Grantee of the Block Grant

First Name	Nora
Last Name	Bock
Agency Name	Missouri Department of Mental Health
Mailing Address	P.O. Box 687
City	Jefferson City

Zip Code	65101-0687
Telephone	573-751-9499
Fax	
Email Address	nora.bock@dmh.mo.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ◉ No

First Name	
Last Name	
Agency Name	
Mailing Address	
City	
Zip Code	
Telephone	
Fax	
Email Address	

IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From	
To	

V. Date Submitted

Submission Date	8/31/2023 5:32:26 PM
Revision Date	8/31/2023 5:33:32 PM

VI. Contact Person Responsible for Application Submission

First Name	Renee
Last Name	Rothermich
Telephone	573-522-8077
Fax	
Email Address	Renee.Rothermich@dmh.mo.gov

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SUPTRS]

Fiscal Year 2024

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

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As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: _____

Name of Chief Executive Officer (CEO) or Designee: Valerie Huhn

Signature of CEO or Designee[1]: _____

Title: Director

Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

STATE CAPITOL
201 W. CAPITOL AVENUE, ROOM 216
JEFFERSON CITY, MISSOURI 65101

(573) 751-3222
WWW.GOVERNOR.MO.GOV

Michael L. Parson

GOVERNOR
STATE OF MISSOURI

July 31, 2018

Odessa F. Crocker
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse Mental Health Services Administration
5600 Fishers Lane, 17th Floor
Rockville, Maryland 20850

Dear Ms. Crocker:

Please be advised that I have delegated signatory authority to the current Director of the Department of Mental Health, or anyone officially acting in this role in the instance of a vacancy, for all transactions required to administer the following Substance Abuse and Mental Health Services Administration (SAMHSA) grants and reports until such time as I may modify or rescind this designation:

1) Substance Abuse Prevention and Treatment Block Grant (SABG),
2) Community Mental Health Services Block Grant (MHBG),
3) Projects for Assistance in Transition from Homelessness (PATH) Grant, and the
4) Annual Synar Report.

Sincerely,

Michael L. Parson,
Governor

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SUPTRS]

Fiscal Year 2024

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2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
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LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
   b. Collecting a certification statement similar to paragraph (a)
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2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: Missouri

Name of Chief Executive Officer (CEO) or Designee: Valerie Huhn

Signature of CEO or Designee[1]: Valerie Huhn

Title: Director

Date Signed: 8/14/2023

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2024

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
Section 1920	Crisis Services	**42 USC § 300x-9**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**

Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
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c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
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The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
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The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Valerie Huhn

Signature of CEO or Designee[1]: _____

Title: Director

Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024. The proposed plans are due to SAMHSA by September 1, 2023.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

STATE CAPITOL
201 W. CAPITOL AVENUE, ROOM 216
JEFFERSON CITY, MISSOURI 65101

(573) 751-3222
WWW.GOVERNOR.MO.GOV

Michael L. Parson

GOVERNOR
STATE OF MISSOURI

July 31, 2018

Odessa F. Crocker
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse Mental Health Services Administration
5600 Fishers Lane, 17th Floor
Rockville, Maryland 20850

Dear Ms. Crocker:

Please be advised that I have delegated signatory authority to the current Director of the Department of Mental Health, or anyone officially acting in this role in the instance of a vacancy, for all transactions required to administer the following Substance Abuse and Mental Health Services Administration (SAMHSA) grants and reports until such time as I may modify or rescind this designation:

1) Substance Abuse Prevention and Treatment Block Grant (SABG),
2) Community Mental Health Services Block Grant (MHBG),
3) Projects for Assistance in Transition from Homelessness (PATH) Grant, and the
4) Annual Synar Report.

Sincerely,

Michael L. Parson,
Governor

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2024

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
Section 1920	Crisis Services	**42 USC § 300x-9**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**

Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

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1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
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I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Valerie Huhn

Signature of CEO or Designee[1]: Valerie Huhn

Title: Director

Date Signed: 8/14/2023

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024. The proposed plans are due to SAMHSA by September 1, 2023.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

MHBG BSCA Supplemental Funding Plan

Bipartisan Safer Communities Act (BSCA) (P.L. 117-159), 2022
Intended start/end date: September 29, 2023 – September 30, 2025
Amount: $1,088,755

Background

The Missouri Department of Mental Health (DMH) is made up of two major program divisions:

- Behavioral Health (DBH)
- Developmental Disabilities (DD)

DMH directly operates inpatient and habilitation facilities for BH and DD, respectively. DMH serves more than 170,000 Missourians with mental illness, developmental disabilities, and substance use disorders. It is a safety net for the state's most vulnerable citizens and their families. Approximately 99% of DMH's 170,000 consumers receive their services through local contracted community-based provider agencies. The DMH mission is:

- Prevention: Reduce the prevalence of mental disorders, developmental disabilities, and substance use disorders.
- Treatment: Operate, fund, and license or certify modern treatment and habilitation programs provided in the least restrictive environment.
- Improve Public Understanding: Improve public understanding and attitudes toward individuals with mental illness, developmental disabilities, and substance use disorders.

Community behavioral health services are delivered through the DMH network of contractual service providers. DBH establishes standards and requirements for delivery of community-based behavioral health services through contracts with its local community mental health centers (CMHCs)/certified community behavioral health organizations (CCBHOs) are designated as the lead agencies for all community-based psychiatric services, as authorized by state statute. Designated service areas by county assure statewide availability of services; allocated funding to the CMHCs/CCBHOs are contractually obligated to BH-designated target populations of:

- Adults with serious mental illnesses as specified by diagnosis and functional abilities;
- Children with serious emotional disturbances as specified by diagnosis and functional scales;
- Individuals with forensic commitments to DMH.

DMH is experienced in disaster response and is known as an innovator and leader in the field of disaster behavioral health. The Missouri Behavioral Health Council (MBHC) (https://www.mobhc.org/) is the provider association and represents these lead agencies utilized in response to disasters in Missouri. A map of CCBHOs by county can be found at https://dmh.mo.gov/mental-illness/help/community-mental-health-centers.

Despite Missouri's reputation for innovation, we do not have the programmatic, technological, human resources or fiscal support/infrastructure or funding to address disasters. Missouri is a fiscally sound and prudent state. Services for persons impacted by trauma, crisis and other disasters rely largely on federal funding and technical assistance. The already taxed public mental health system has no additional or predictable capacity to accommodate the unique community outreach model and challenging needs in our communities without additional assistance.

In addition, a school shooting occurred just one year ago in the St. Louis area, and the community is dealing with repetitive trauma from other events that continue to layer upon the taxed system. The St. Louis area remains one of the hardest hit from the pandemic and past disaster events to include flooding, the death of Michael Brown/Ferguson, the Coldwater Creek radioactive material and the most recent school shooting.

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We also know that behavioral health issues have been exacerbated during the pandemic, especially among young adults. In 2021, suicide was among the top 9 leading causes of death for people ages 10-64 and the second leading cause of death for people ages 10-14 and 20-34, according to the CDC. That same year, Missouri's suicide rate was 19.1 per 100,000 residents, with more than 1,174 Missourians dying by suicide. As the largest national suicide prevention services, the 988 Suicide & Crisis Lifeline offers in-the-moment crisis support for anyone experiencing a mental health, suicide, or substance use crisis.

Crisis Set Aside
DMH, behavioral health providers, and community partners have been working diligently to establish a comprehensive "no-wrong-door" integrated crisis response system with the 988 at its core. According to data provided by Vibrant Emotional Health on 988 volume, Missouri 988 centers have answered 46,647 calls. This represents a 65% increase in call volume from June of 2022 to 2023. Missouri's in-state call answer rate since the national launch is 91%. The significant increase in volume highlights the growing demand for crisis services in Missouri. This underscores the need for expansion of behavioral health crisis services to ensure that Missouri's crisis response continues to meet the needs of individuals in crisis. By investing in the expansion of crisis services, Missouri will be well-positioned to further enhance access to timely and effective support to those reaching out, including those experiencing a suicide crisis.

Item to be funded:

1.0 FTE Disaster and Crisis Response Liaison to coordinate crisis response and emergency preparedness plans and implementation. The FTE is shared by the Division of Behavioral Health and Office of Disaster Services (ODS). This temporary position is classified as a Senior Program Specialist with a working title of Disaster and Crisis Response Liaison with .5 FTE being responsible for the coordination of all items listed in the Disaster Services request. The individual works alongside the other ODS staff and reports to the Director of Disaster Services. In addition, this position works alongside crisis services staff within the DBH to coordinate and integrate crisis services within ODS. This position is co-supervised by the Director of Disaster Services and the DBH Crisis Services Coordinator. The Disaster and Crisis Response Liaison collaborates with crisis response and behavioral health providers to enhance the Behavioral Health Strike Team (BHST) and emergency preparedness plans to ensure providers have the capacity they need to respond to natural and human-caused disasters or other type of traumatic event. This would include the coordination of activities between DBH, DD, 988 centers, mobile crisis response providers, behavioral health providers, and other emergency response providers, including emergency managers. **$112,980** (includes salary, fringe, indirect).

First Episode Psychosis Set Aside
DMH sees the value in prioritizing early intervention for individuals experiencing their First Episode of Psychosis (FEP). Set aside funding will be used to contract for 1.0 FTE at MBHC to develop the workforce with an emphasis on first episode psychosis. By equipping the community behavioral health workforce with evidence-based practices for this population, DMH will promote enhanced clinical expertise embedded broadly within community based services, realize more positive life outcomes for individuals and families experiencing psychosis, and potentially demonstrate healthcare savings through reduced emergency room use and hospital admissions. Set Aside funding will also be used to support ongoing improvements within the community behavioral health workforce by providing select evidence based

training and/or evidence informed educational opportunities that highlight first episode care and the importance of early identification and intervention.

Items to be funded:

- FTE at MBHC to develop the workforce with an emphasis on First Episode Psychosis. **$108,876**

1. **Describe any plans to utilize the BSCA supplemental funds to develop/enhance components of your state's mental health emergency preparedness and response plan that addresses behavioral health. Please include in your discussion how you plan to coordinate with other state and federal agencies to leverage crisis/mental health emergency related resources.**

DMH will collaborate with crisis contact centers (988 and local hotlines) and mobile crisis response providers to develop a statewide behavioral health crisis response and emergency preparedness plan to ensure crisis contact centers and crisis response providers have the capacity they need to respond to sudden and large spikes in call, text, or chat volume as well as spikes in mobile crisis response following a public service announcement, disaster, or other type of traumatic event. This will include coordinating with ODS and other emergency response providers, including 911/law enforcement.

The combination of exposure to trauma, demanding schedules, and physically challenging roles puts first responders at risk for mental health issues such as depression, post-traumatic stress, suicidal behaviors, and reduces their ability to respond effectively to those in the community who are in crisis. Missouri has recently passed legislation to assist first responders get mental health treatment and DMH has formed the following partnerships to provide first responder assistance:

- Missouri State Highway Patrol (MSHP)
    - Critical Incident Stress Management (CISM) training – DMH has partnered with MSHP to conduct comprehensive, integrated, systematic, and multi-component trainings designed to assist employees involved in a traumatic and/or critical event to return to or maintain an effective level of functioning. CISM may include a combination of assistance services to include individual or group debriefing after a critical incident.
    - Post Critical Incident Seminars (PCIS) – DMH has partnered with MSHP to conduct multiple PCIS sessions. PCIS targets first responders who experience a critical incident and is led by CISM trained peer team members. PCIS is a three-day event and funding allows at least 35 first responders and their significant other to attend at no cost. The goal of PCIS is to provide interpersonal support, education, therapy, and resources to address trauma experienced by first responders.
- Missouri Department of Corrections (DOC)
    - CISM – DMH has partnered with DOC to provide CISM training (similar to MSHP partnership described above).
    - PCIS – DMH has partnered with DOC to provide PCIS sessions for correctional officers and probation officers (similar to MSHP partnership described above).

Item to be funded:

- Disaster and Crisis Response Liaison (previously described above) to coordinate crisis response and emergency preparedness plans and implementation. **$112,980** (includes salary, fringe, indirect)
- MSHP has dedicated funding to support two PCIS events per year, but there is always a waitlist of first responders for PCIS. Funds will be utilized to add an additional MSHP PCIS session to serve

additional first responders and their spouses. A small portion of funds ($5,000 or less) will go to supplies for the PCIS event. **$35,000**

- Two CISM trainings will be conducted. The first CISM training will be specific to DOC staff and second training will target first responders and include new CIT regional coordinators. **$18,900**

2. Describe any plans to utilize the BSCA supplemental funds to develop/enhance a state behavioral health team that coordinates, provides guidance, and gives direction in collaboration with state emergency management planners during a crisis.

ODS continues to enhance the state disaster BHST that responds to critical events in the state. The intent and purpose of the BHST is to quickly deploy trained individuals from a CMHC/CCBHO or other behavioral health provider and the ODS and establish communications with the impacted region/county/city/facility to determine the level of trauma and develop a strategy to deliver psychological first aid to survivors and first responders.

ODS and the CMHC/CCBHO have spent the last year enhancing the concept of operations to allow for better response to citizens impacted by natural and human caused disasters. The BHST provides behavioral health support to survivors, responders, and other disaster workers. Additionally, the BHST works directly with other state agencies to coordinate other state or federal assistance, if needed.

During the pandemic, half of the BHST membership was lost due to retirement and attrition. Over the last year, we have been able to recruit to get new members and have added additional membership to the team. This continued funding enables work to continue on expanding the team through several avenues. The funding request would allow staff to travel to conferences to present and exhibit on the BHST (to include conference and travel fees) and to create culturally appropriate promotional materials to explain what the BHST is, how to request it, and recruit new members. This amount would also allow us to develop other promotional materials to be used by the BHST members to help distinguish who they are upon deployment.

The BHST has responded to several mass casualty events in Missouri over the last several years to include the Branson Duck Boat accident, an Amtrak train derailment, and a school shooting in St. Louis. Through these deployments, DMH has found that localized and smaller responses is where the BHST is more successful. The larger scale events, like the school shooting, showed us that a larger number of BHST members are needed as it was a struggle to keep up with the demand on the behavioral health system. This funding will assist the state in enhancing the BHST's training and education in preparation to deploy for future events around the state through training with subject matter experts in suicide prevention and trauma from around the country.

In addition, the state has previously held a shortened summit to train BHST on various subjects. This funding will allow DMH ODS to expand this to be a more specialized training for BHST members by hosting the first two-day conference designed solely for the BHST members. During this training, DMH ODS will bring in subject matter experts to educate and prepare the BHST members on various types of responses like mass violence and other mass casualty events that may happen in the community. This will assist the BHST to be better prepared when something happens. In addition, this conference would allow for a tabletop exercise to be completed to test the information learned during the conference and other trainings in order to identify gaps and lessons learned before future responses.

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Additional information on the Missouri BHST can be found at: https://dmh.mo.gov/disaster-services/behavioral-health-strike-team. The FTE, Disaster and Crisis Response Liaison, will assist with coordinating DBH crisis services with the BHST.

Items to be funded:

- Travel to conferences in MO to present and exhibit on the BHST. Development and delivery of promotional materials of varying types for the BHST to include brochures, videos, social media, and other promotional items. Development of vests and badging for the BHST. **$50,000**
- Specialized training is required for the BHST members which includes NOVA (National Organization for Victims Assistance): the basic course, Incident Command, and Psychological First Aid. BHST members are required to take two annual trainings on various topics around trauma. This includes subject matter experts' trainings. Total request for 1 Basic NOVA and 2 Advanced NOVA courses for a total of **$105,000**
- Development and launch of the first MO BHST disaster two-day conference. This will allow us to bring in subject matter experts, conference fees, lodging, meals, and speaker fees (to include travel expenses) for all BHST and ODS members. **$150,000**
- Development of online training courses for current and future BHST members on topics around trauma, disaster preparedness, emergency planning writing, how to include behavioral health in emergency plans, and other relevant topics. **$50,000**
- Provide suicide prevention/intervention training for crisis and other mental health emergency responders. **$20,000**

3. **Describe any plans to utilize the BSCA supplemental funds to develop/enhance a multidisciplinary mobile crisis team that can be deployed 24/7, anywhere in the state rapidly to address any crisis.**
DMH is currently enhancing the statewide mobile crisis response system. For crisis related disasters, the Disaster and Crisis Response Liaison, assists with coordinating DBH mobile crisis response services and facilitates state emergency response efforts to ensure timely and adequate response. DMH will also provide evidence-informed disaster/crisis debriefing training for emergency response providers including law enforcement, behavioral health providers and crisis centers.

The Missouri Crisis Intervention Team (MO CIT) program is a partnership with law enforcement and other first responders, behavioral health providers, hospitals, courts, individuals with lived experience, and community partners. The goal of CIT is to promote more effective law enforcement interactions with individuals in crisis, connect individuals in crisis with available resources, improve safety of the first responder and the individual in crisis, reduce stigma, and expand and sustain CIT across the state. There are 34 local CIT Councils and CIT officers in 110 of Missouri's 114 counties. The Missouri CIT program is known as a national leader in CIT and is recognized annually at the CIT International Conference for their first responder wellness programs. MO CIT will celebrate its 10 year anniversary at the 2024 CIT state conference which brings together 500-600 law enforcement, first responders, behavioral health, community stakeholders, and individuals with lived experience.

Mobile crisis response teams respond to an individual in crisis wherever the crisis is occurring, including at someone's home, workplace, school, or other community location. Mobile crisis response teams respond without law enforcement assistance wherever possible, however, there are times that mobile crisis response providers request a trained CIT officer respond to the situation depending on the acuity and situation of the crisis. There are also times that mobile crisis response will respond with a CIT officer

to offer adequate crisis intervention and de-escalation. This approach ensures that warm handoffs and connections to the most appropriate emergency response provider occurs and individuals receive the best care and support possible.

MO CIT has recently hired six regional coordinators who take direction from the MO CIT State Coordinator and assist the Training Coordinator as directed and promote/expand CIT across the state by following the Missouri Model of CIT. Regional coordinators also assist in first responder wellness and coordinate first responder debriefings for critical incidents that occur in their region.

The First Responder Provider Network (FRPN) is a network of trained behavioral health professionals identified by MO CIT who specialize in helping first responders struggling with depression, anxiety, relationships, post-traumatic stress symptoms, and more. These providers understand the unique professional culture and are and vetted by first responders. There are currently 50 clinicians participating in the FRPN and their contact information can easily be accessed on the MO CIT Law Enforcement Wellness App.

MO CIT is a critical component of the Missouri behavioral health crisis response system, as law enforcement involvement is sometimes necessary for proper response during a behavioral health crisis. The MO CIT is a robust program that prioritizes training of law enforcement officers to ensure the best possible outcome for an individual in crisis. The additional funding to support MO CIT and the FRPN will enhance the program infrastructure and support the collaboration and education of crisis trained law enforcement.

Item to be funded:

- Disaster and Crisis Response Liaison (previously described) to coordinate crisis response and emergency preparedness plans and implementation. **$112,980** (includes salary, fringe, indirect)
- The CIT 10th annual conference to highlight the accomplishments of CIT and enhance partnerships and collaboration with first responders in Missouri. **$73,500**
- Administrative support for the FRPN to include meetings to promote collaboration, provide education, and formalize the network. **$7,000**

4. **Describe any plans to utilize the BSCA supplemental funds to develop/enhance crisis/mental health emergency services specifically for young adults, youth and children, or their families, including those with justice involvement and having SED/serious mental illness (SMI).**

DMH has explored the implementation of a youth/young adult specific mobile crisis response team pilot over the past year. DMH has determined that mobile crisis response services should be available and well-equipped to provide community-based crisis intervention to any Missourian regardless of age. DMH is, however, prioritizing additional training for mobile crisis response providers on responding to youth and young adults in crisis. In addition, DMH is enhancing crisis service promotion efforts to ensure all Missourians, including youth, young adults, and their families are aware of the services available throughout the state. This funding will assist in creating promotional materials to enhance public awareness and education of behavioral health crisis and mental health emergency services. The Disaster and Crisis Response Liaison will assist with the coordination of youth and young-adult focused mobile crisis response training and the development and dissemination of crisis and mental health emergency

service promotional materials to increase awareness and provide information about available services and supports.

Item to be funded:

- Youth/Young Adult Focused Mobile Crisis Response Training. **$20,000**
- Behavioral Health Crisis & Mental Health Emergency Service Promotional Materials. **$122,375**
- Disaster and Crisis Response Liaison to coordinate the development and dissemination of promotional materials regarding behavioral health and mental health emergency resources. **$112,980** each year; includes salary, fringe, indirect.

5. **Describe any plans to utilize the BSCA supplemental funds to develop/enhance services provided to communities that are affected by trauma and mass shootings/school violence.**

The American Psychological Association (APA) indicates that the regularity of which the US is seeing mass shootings is impacting mental health; creating stress and "dulling compassion" that cause concern and demonstrate the need for change. Missouri has most recently seen a school shooting on October 24, 2022, where the gunman had around 600 rounds of ammunition in the school. He was shot and killed by police inside the school. Before he was killed, he killed two people – a student and a teacher – and injured many others. An APA article shows that more kids are expressing they are afraid of what might happen at their school. Those concerns have been linked to elevated anxiety levels and fear. The stress is "embedded within the context of the pandemic, economic challenges, political polarization, climate-related disasters, and other factors..." This is seen as a "cascade of collective traumas." It is known that for witnesses and survivors the suffering can be severe. Studies have shown that there are increases of mental health disorders and other conditions after a mass shooting. https://www.apa.org/monitor/2022/09/news-mass-shootings-collective-traumas

Recovery for individuals and communities from mass violence can take years and can have a very negative impact on communities. Taking into consideration the layers of trauma already embedded in our communities from natural disasters like flooding and tornados along with human-caused disasters of school shootings, gun violence, weapons/threats on campus, and what we continue to see from COVID, we know that additional resources are needed to support the community.

A lesson learned from other mass violence events, including the St. Louis school shooting, is the need for support in schools for planning for various crisis events before the event happens. Many schools bring in trainers for PREPaRE *after* a school shooting to work on recovery. The DMH ODS is partnering with Burrell Behavioral Health Center, who is the only behavioral health agency in MO to have trainers for the PREPaRE model, to bring this training to education communities across MO. This funding will allow us to bring additional PREPaRE trainings to areas in MO *before* tragedy strikes. https://www.nasponline.org/professional-development/prepare-training-curriculum/about-prepare

In addition, this funding will allow us to expand mass violence resources and TeachWell for educators across MO. TeachWell was developed in response to the St. Louis, MO school shooting. TeachWell was designed after 32 schools (outside of where the shooting happened) in the St Louis school district expressed an increase in need for support for their educators and students around wellness and mental health. In addition, we have had several schools around the state reach out for support after threats of mass violence have been made at their local schools. DMH ODS has worked with Learfield, a media and marketing agency, to develop and promote mass violence resources for educators and communities after

mass violence events. This funding will allow DMH ODS to continue to address mass violence by developing, enhancing, and sharing digital and social content in affected areas and promoting help for affected Missourians including teenagers, young adults, parents, influencers, teachers and other educators, and first responders.

DMH supports residents dealing with these incidents, acknowledging the normality of emotional distress such as anxiety and sleep troubles. A beacon of hope shines through the offer of free, confidential support via calls, texts, or chats to the crisis hotline 988, connecting individuals with trained counselors. Local resources stand ready to aid Missourians with counseling services and education. The plan comprises three goals: elevating help-seeking through 988 engagements, fostering professional education through trauma-informed videos, first responder educational series and TeachWell wellness for educators. DMH will direct individuals to valuable resources by boosting web traffic.

Items to be funded:

- PREPaRE trainings to be offered to educational entities and behavioral health providers throughout MO. **$12,000**
- TeachWell and Mass Violence campaign. **$50,000**
- Content Hub for all projects developed to be utilized and promoted around the state. **$12,000**

6. **Describe any plans to utilize the BSCA supplemental funds to develop/enhance culturally and linguistically tailored messaging to provide information about behavioral health in a crisis/mental health emergency and/or to identify culturally/linguistically appropriate supports for diverse populations.**

The Disaster and Crisis Response Liaison is assisting with the development of culturally and linguistically tailored messaging to provide information about behavioral health in a crisis/mental health emergency and/or to identify culturally/linguistically appropriate supports for diverse populations. Over the past year, DMH has collaborated with the Missouri Office of Refugee Administration and others to gather insight into what materials may be most useful in different languages and representative of different cultural considerations. Through a series of committee discussions, DMH has gathered feedback on the cultures and languages spoken by Missouri's high risk populations and is developing materials that reflect this information. Through these discussions, the need for increased funding to support these efforts was identified as information regarding other crisis response services is pertinent to share concurrently. This continued and increased funding enables work to continue on enhancing access to behavioral health crisis services for all Missourians.

Items to be funded:

- Disaster and Crisis Response Liaison to coordinate the development and dissemination of culturally/linguistically appropriate educational materials. **$112,980** (includes salary, fringe, indirect)
- Develop and disseminate culturally/linguistically appropriate educational materials. **$71,124**

7. **What other mental health emergency/crisis behavioral health practices or activities does the state plan to develop or enhance using the BSCA supplemental funds?**

The Victim Information Center (VIC) is a centralized location designated after a mass casualty event intended to support victim identification. At the VIC, family members can obtain information on the status of the event, provide identifying information about the victims, receive death notifications, and obtain

emotional care and other supportive services. Behavioral health team members are assigned different duties depending on their licensed status within the VIC.

A VIC would be stood up at the direction of the Missouri State Emergency Management Agency (SEMA) following a disaster occurring in or impacting the state, resulting in multiple fatalities, injuries and/or missing persons. The VIC is coordinated by local, state, and federal response agencies including health, emergency management, and Coroner/Medical Examiners.

The VIC is a component of fatality operations and deployed when requested locally. VIC and morgue operations are coordinated through the Missouri Mortuary Operations Response Team (MO MORT-1), the state's fatality management team. ODS coordinates, facilitates and runs the behavioral health unit response in the VIC. Members of the VIC team are a part of the BHST and have specialized training for VIC operations that are not part of the BHST required trainings. Non-licensed behavioral health VIC team members staff the reception desk and serve as greeters. Licensed behavioral health professionals serve as members of the Care Teams. The Care Teams are made up of behavioral health professionals and chaplains trained to assist families in the bereavement process. A family going through the VIC will have the same Care Team throughout the process. The Care Team assists the MO State Highway Patrol (MSHP) with death notifications. The Care Team guides the family through the process including the interview and completion of the Victim Identification Profile (VIP) process, to death notification, answering any questions or concerns along the way.

Items to be funded:

- Full scale exercise of the VIC to include costs of exercise, hotels, staff fees, and travel expenses. **$20,000**
- Development of VIC materials to include two printers, brochures in multiple languages, VIC signage and vests for team members working, and additional supplies as discovered needed during the full scale exercise. **$50,000**

8. Clearly describe the proposed/planned activities utilizing the funds for both FY 2022 and FY 2023 as two separate sections, including an estimated budget for each year. States will be required to report on what activities have been completed using this funding.

FFY 2024 (September 29, 2023 – September 30, 2025) Budget Breakdown

Proposed Activities	Amount
Treatment:	
Services in communities impacted by trauma and mass shootings and recruitment of BHST	$100,000
PCIS	$35,000
FRPN	$7,000
TOTAL:	**$142,000**
Prevention:	
Development of culturally/linguistically appropriate educational materials	$71,124
TeachWell and mass violence	$62,000

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Behavioral Health Crisis & Mental Health Emergency Service promotional materials	$122,375
TOTAL:	**$255,499**
Training:	
Youth/Young Adult Focused Mobile Crisis Response Training	$20,000
VIC team training	$70,000
PREPaRE trainings	$12,000
BHST Member Annual Trauma Training	$105,000
MO BHST Disaster Conference	$150,000
Suicide Prevention Training for Crisis & Mental Health Emergency Providers	$20,000
CISM	$18,900
MO CIT Conference	$73,500
TOTAL:	**$469,400**
Crisis Set Aside (5%):	
Disaster and Crisis Response Liaison, 1.0 FTE	$112,980
TOTAL:	**$112,980**
First Episode Psychosis Set Aside (10%):	
MBHC Position (1.0 FTE) to develop workforce with emphasis on first episode psychosis.	$108,876
TOTAL:	**$108,876**
Total:	**$1,088,755**

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL).
Standard Form LLL (click here)

Name
Valerie Huhn

Title
Director

Organization
Missouri Department of Mental Health

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's M/SUD prevention (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. In general, the overview should reflect the MHBG and SUPTRS BG criteria detailed in "Environmental Factors and Plan" section.

Further, in support of the **Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government**, SAMHSA is committed to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Therefore, the description should also include how these systems address the needs of underserved communities. Examples of system strengths might include long-standing interagency relationships, coordinated planning, training systems, and an active network of prevention coalitions. The lack of such strengths might be considered needs of the system, which should be discussed under Step 2. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Missouri's Behavioral Health System of Care

Overview and structure

With a population of over six million people, Missouri provides a rich diversity of rural, suburban and urban landscapes. The state has 114 counties and the independent city of St. Louis. Approximately 82.5% of the population is Caucasian, 11.7% are African-American, 2.3% are Asian, and 2.7% are of two or more races. About 4.8% of the state's population is Hispanic (U.S. Census Bureau, 2020). Large populations of African-Americans are present in the state's metropolitan areas of St. Louis and Kansas City, as well as the rural southeast "Bootheel" area. The state's largest Hispanic population is in the Kansas City area. Although the state does not have any federally recognized tribes, small populations of Native Americans make their home near the Oklahoma border. The American Indian Council Region 7 is located in Kansas City, Missouri (American Indian Council, 2022). Additionally, the Heart of America Indian Center, Inc., d/b/a Kansas City Indian Center, operates as the Kansas City area's only multi-purpose social service agency for American Indians. The center was founded as a formal, tax-exempt, 501(c)(3) organization in 1971 to accept federal, state, and private funds for social programs (Kansas City Indian Center, Unknown). Approximately 392,041 Missouri residents are veterans (US Department of Veteran's Affairs, 2022).

At $295.73 billion in 2021, Missouri's Gross State Product (GSP) ranked 22nd among states (Missouri Economic Research and Information Center, 2023). As of June 2023, the state's unemployment rate stood at 2.6%, which is slightly lower than that for the country as a whole (3.5%) (Missouri Department of Labor and Industrial Relations, 2023). Missouri has 13 counties plus the independent city of St. Louis that have poverty rates of at least 20% (United States Census Bureau, 2021). Most of these counties are located in the southern portion of the state.

The Missouri Department of Mental Health (DMH) is one of 16 state agencies under the executive branch of state government. DMH collaborates on initiatives with other state agencies including the Departments of Corrections (DOC), Transportation (DOT), Elementary and Secondary Education (DESE), Health and Senior Services (DHSS), Public Safety (DPS), and Social Services (DSS). DSS is the Medicaid authority for the state. DMH's close, collaborative relationships with DOC and DSS, in particular, are strengths to the state's behavioral health system. The principal missions for DMH as established in state law are to: 1) Reduce the incidence and prevalence of mental disorders, developmental disabilities and alcohol or drug abuse through primary, secondary and tertiary prevention; 2) Maintain and enhance intellectual, interpersonal and functional skills of individuals affected by mental disorders, developmental disabilities or alcohol or drug abuse by operating, funding and licensing modern treatment and habilitation programs provided in the least restrictive environment possible; and 3) Improve public understanding of and attitudes toward mental disorders, developmental disabilities and alcohol and substance use (Missouri Revisor of Statutes 1980). DMH has representation on various interagency groups including:

- 988/911 Committee;
- Access and Functional Needs Committee;
- Behavioral Pharmacy Management (BPM);
- Behavioral Health Workgroup;

- Community Behavioral Health Liaisons (CBHL) Meetings;
- Crisis Intervention Teams (CIT) Meetings;
- Emergency Room Enhancement (ERE) Meetings;
- Certified Community Behavioral Health Organizations Prospective Payment System Leadership Group;
- Children and Youth in Disasters Committee;
- Children's Division Healthcare Coordination Committee,
- Continuity of Operations Planning;
- Council for Adolescent and School Health (CASH);
- DOC/DMH Oversight Committee;
- DSS Critical Incident Review Panel;
- Early Childhood Comprehensive System Steering Committee;
- Eating Disorders Council;
- Emergency Preparedness Committee;
- Emergency Room Workgroup;
- Families First Implementation
- Governor's Challenge to Prevent Suicide amongst Service Members, Veterans, and Their Families;
- Governor's Council on Disability;
- Governor's Faith-based and Community Service Partnership for Disaster Recovery;
- Higher Education Student Mental Health Task Force;
- Homeland Security Advisory Committee;
- Housing Liaison Meeting;
- Housing Opportunity Committee;
- Human Trafficking Task Force (Missouri Attorney General's Office)
- Impaired Driving Subcommittee, Coalition for Roadway Safety;
- Individualized Placement and Support Collaborative Meetings;
- Improving Community Treatment Success (ICTS) Oversight Team;
- JRI Executive Oversite Committee;
- JRI Behavioral Health Work Group;
- JRI Crisis Response Work Group;
- JRI Evidence-based Practices in DOC Work Group;
- JRI Victim's Work Group;
- JRI Data Sharing Work Group;
- Kids Win Missouri Child Care Advisory Group;
- Local Continuum of Care Meetings;
- Local Recovery Coalitions;
- Maternal/Fetal Health Workgroup;
- Maternal, Infant and Early Childhood Home Visiting Program State Steering Committee;
- Midwest Consortium on Problem Gambling and Substance Abuse Committee;
- Missouri 988 Task Force;
- Missouri Affiliate of the NO Fetal Alcohol Syndrome (NOFAS);
- Missouri Alliance for Drug Endangered Children;
- Missouri Alliance to Curb Problem Gambling;

- Missouri Behavioral Health Council;
- Missouri Behavioral Health Epidemiology Workgroup;
- Missouri Coalition of Recovery Support Providers;
- Missouri Coordinated School Health Coalition;
- Missouri Head Start Advisory Council;
- Missouri Treatment Courts Coordinating Commission;
- Missouri Treatment Courts Committee;
- Missouri Injury and Violence Prevention Advisory Council;
- Missouri Interagency Council on Homelessness
- Missouri Lifespan Respite Coalition;
- Missouri Prevention Partners Coalition;
- Missouri School-Based Health Alliance State Advisory Council;
- Missouri School Safety Academy Advisory Council;
- Missouri Suicide Prevention Network (MSPN);
- Missouri Suicide Prevention State Plan Writing Workgroup;
- Missouri Children's Justice Act Task Force;
- Missouri Viral Hepatitis Stakeholder Workgroup;
- Missouri Zero Suicide Learning Collaborative;
- Missouri Suicide Prevention Stakeholder Meeting;
- Missouri Crisis Services Committee;
- Missouri Coordinated School Health Coalition;
- Missouri Interagency Transition Team;
- MO HealthNet (Medicaid) Behavioral Health Committee for Health Care Reform;
- MO HealthNet (Medicaid) Managed Care Quality Assurance & Improvement Advisory Group;
- MO HealthNet (Medicaid) Stakeholder Advisory Committee Behavioral Health Carve In Project;
- National Treatment Coordinators, subgroup of National Association of State Alcohol and Drug Abuse Directors (NASADAD);
- Office of Childhood;
- Peer Respite Crisis Stabilization Meetings;
- Primary Care/DMH Integrated Care Workgroup;
- Recovery Community Centers Meeting;
- Statewide Advisory Council;
- Statewide Sequential Intercept Model Steering Committee;
- Sexual Violence Prevention Planning Stakeholders Committee;
- Show Me Response (disaster & emergency coordination);
- Stakeholders Advisory Group;
- State Mass Care Committee;
- State of Missouri Brain Injury Advisory Council;
- State Tobacco Community of Practice;
- Substance Use Disorder Workgroup;
- Show Me Farm Safety Committee Prescription Medication Advisory Committee (DSS)
- Supporting Young People Meetings;

- Tobacco Prevention and Control Strategic Plan Prevention Workgroup;
- The Missouri Interagency Transition Team;
- Workforce Innovation and Opportunity Act Committee;

DMH is comprised of the Divisions of Behavioral Health (DBH), Developmental Disabilities (DD), and Administration. The Department's supportive offices include the Offices of Deaf Services, Constituent Services, and Comprehensive Child Mental Health. In November 2012, Missouri voters approved a measure that prohibits the Governor or any state agency from establishing or operating a state-based health insurance exchange without legislative or voter approval. On August 4, 2020, Missouri voters approved an initiated constitutional amendment to expand Medicaid. However, the Missouri legislature did not appropriate funds to support the expansion. Subsequently, a petition was filed in the Circuit Court of Cole County, Missouri, challenging the legislature's failure to fund Medicaid expansion. The Circuit Court found that the amendment was unconstitutional. The decision was appealed to the Missouri Supreme Court, which unanimously found on July 22, 2021 that the amendment was constitutional and remanded the case back to the Cole County Circuit Court to address implementation. On August 10, 2021, the Circuit Court found that Missouri is required to open Medicaid eligibility to the expansion population as set out in the amendment. The expansion opened up Missouri's Medicaid program to approximately 275,000 additional individuals making less than $18,000 per year.

The director of the Department of Mental Health (DMH) is appointed by the Missouri Mental Health Commission and confirmed by the state Senate. Comprised of seven members appointed by the Governor, the Mental Health Commission serves as the principal policy advisory body to the department director. The Commission, by law, must include an advocate of community mental health services; a physician who is an expert in the treatment of mental illness; a physician with an awareness of developmental disabilities; a member with business expertise; an advocate of substance use treatment; and a citizen who represents the interests of consumers of developmental disabilities services.

The Department Director appoints the division directors. The director of the Division of Behavioral Health (DBH) is responsible for leading and managing the DBH division; directing policy and strategic plans for DBH; coordinating with other state officials; and representing DBH in discussions, negotiations, and partnerships with other state and federal organizations. DBH is organized into the following functional units:

- Community and Regional Operations,
- Psychiatric Facility Operations,
- Children's Services,
- Recovery Services,
- Prevention and Mental Health Promotion,
- Administration (fiscal), and
- Data and Research.

Community and Regional Operations

Included under Community and Regional Operations are all mental health and substance use community-based treatment programs, the Substance Awareness Traffic Offender Program (SATOP), Healthcare Homes, certification, and fidelity review. In addition to leading and

managing these programs, the Deputy Director of Community Operations is also responsible for working with key stakeholders, to include other state agencies, to improve community-based services. The DBH contracts with 62 community-based agencies for the provision of substance use treatment and/or psychiatric rehabilitation services: 34 for substance use treatment only, 13 for psychiatric rehabilitation services only, and 12 for both. The certification standards of care contain core rules for Psychiatric and Substance Use Disorder Treatment Programs, updated in 2019, and will continue to be reviewed/updated every 5 years, which apply to both mental health and substance use programs. Separate certification standards of care for mental health and substance use disorder treatment programs include the specific service delivery requirements for each program, including staff qualifications, required services, and environmental and safety practices. DBH staff conduct annual billing reviews of contracted community organizations. DBH certifies 137 organizations for substance use treatment, and 77 organizations for mental health treatment.

The Department of Mental Health's (DMH) vision statement specifies, "Missourians are safe, valued and supported community members." (Missouri Department of Mental Health, 2022). Core standards require that services be delivered in a manner that is responsive "to each individual's developmental needs, cultural background, gender identity, gender expression, language and communication skills, sexual orientation, and other factors as indicated" (Department of Mental Health 9 CSR 10-7.010, 2020). DMH requires through contract language that contractor staff be competent in the cultural, racial, and ethnic patterns of the geographic area being served. Interpreting services are to be available to individuals in treatment whose preferred language is a language other than spoken English. DMH's Office of Deaf Services (ODS) is responsible for consultation and technical assistance to DMH facilities and contracted providers delivering behavioral health services to eligible individuals who are deaf, hard of hearing, or from cultural and linguistic minority groups. The ODS also establishes minimum competencies for behavioral health interpreters, consistent with Title II of the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, the federal Culturally Linguistically Appropriate Services Standards, and Missouri Interpreter Certification System rules. Consumer complaints and grievances received either by DMH's Office of Constituent Services or by the provider organization are reviewed by DMH clinical staff for issues with cultural competency. DMH's information system collects data on consumer characteristics including race, ethnicity, preferred language, hearing status, and gender identity (ISO 5218). Such data is aggregated by geographical areas for analysis. DMH is a provider of cultural competency trainings for the state's behavioral health and prevention workforce. Cultural competency training is included in DMH's annual Spring Training Institute that is attended by approximately 800 behavioral health and human service professionals.

All individuals in need of behavioral health services from facilities operated by Division of Behavioral Health (DBH) contracted service providers receive an initial assessment. For individuals needing substance use treatment, an individual receives a structured interview completed by a Qualified Addiction Professional (QAP), with a diagnosis rendered by a licensed diagnostician. For individuals seeking services from the Substance Awareness Traffic Offender Program (SATOP), the self-administered Driver Risk Inventory II (DRI-II), in conjunction with an individualized interview with a SATOP Qualified Professional (SQP), determines the level of program placement. Individuals seeking Certified Community Behavioral Health Organization (CCBHO) services shall receive a preliminary screening and risk assessment at first contact to determine acuity of need. Emergency, urgent, or routine service needs shall be identified and

addressed. Following the preliminary screening, qualified staff shall conduct an initial evaluation and further screening, and provide needed services as indicated by the initial evaluation. Additional screening shall include, but is not limited to: 1) Depression screening for all adolescents age thirteen (13) to eighteen (18) years of age; 2) Depression screening for all adults age nineteen (19) and older; 3) Suicide risk assessment for all adolescents and adults diagnosed with major depression; 4) Brief health screen, as specified by the department; 5) Alcohol use disorder screening; and 6) Substance use disorder screening.

DBH substance use treatment programs include the Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs, Substance Awareness Traffic Offender Program (SATOP), Department of Corrections (DOC) programs and State Opioid Response (SOR) programs.

The CSTAR programs are designed to provide an array of comprehensive, individualized, treatment services with the aim of reducing the negative impacts of substance use disorders to individuals, family members and society. Available services include assessment; individual and group counseling; group rehabilitative support; community support; peer support; family support; residential or housing support, as appropriate; trauma-specific individual counseling and group education; individual co-occurring disorders counseling; family therapy; and medications, physician and nursing services to support medication therapy. In July 2022, CSTAR services transitioned to the utilization of the American Society of Addiction Medicine (ASAM) criteria within substance use services. This continuum of care, based on criteria placement, shifts from a fee for service pay structure to team based billing. CSTAR providers have until September 2024 to adopt ASAM. During this transition period, providers will operate utilizing CSTAR with ASAM or the previous CSTAR structure.

CSTAR without ASAM features levels of care including outpatient, intensive outpatient, and residential care that vary in duration and intensity, with specific services received based on individuals' needs. Individuals may enter treatment at any level in accordance with eligibility criteria. A designated DMH staff, acting as the State Opioid Treatment Authority (SOTA), provides oversight and clinical assistance to the Opioid Treatment programs to ensure that treatment is consistent with best practices and federal requirements. The CSTAR programs are targeted for specialized populations including Women and Children (11 contracts), the General Population (19 contracts), the Opioid Program (10 contracts), and Adolescents (5 contracts). DBH's CSTAR programs are the only substance use treatment programs reimbursable by Medicaid in the state. In 2011, DBH was successful in amending the Medicaid state plan to include a CSTAR Modified Medical Detoxification Program (4 contracts). In an effort to expand residential access for consumers, the 1115 IMD waiver, currently in development and available for providers to utilize if approved, seeks to expand the current maximum capacity of 16 beds.

DBH also maintains the Primary Recovery Plus (PR+) program (6 contracts). Similar to the CSTAR General Population Program, PR+ offers a full continuum of services within multiple levels of care to assist those individuals without Medicaid coverage. DBH oversees several programs designed specifically for Department of Corrections' offenders under community-supervision who need substance use treatment. These include CSTAR Women and Children Alternative Care (2 contracts), and Improving Community Treatment Success (ICTS) (6 contracts). In 2019, DOC received additional state funds to expand the Improving Community

Treatment Success (ICTS) program to additional counties. As established in all DBH SUD contracts, priority populations for substance use treatment include:

- Women who are pregnant and have injected drugs in the prior 30 days;
- Women who are pregnant;
- Persons who have injected drugs in the prior 30 days;
- Civil involuntary commitments;
- High risk offenders referred by the Department of Corrections' institutions and Division of Probation and Parole via referral form and protocol;
- Applicants and recipients of Temporary Assistance for Needy Families (TANF) referred by the Department of Social Services, Family Support Division, via referral form and protocol; and
- Adolescents and families served through the Children's System of Care.

All contracted agencies providing substance use treatment are required to screen individuals requesting services to determine potential eligibility as a priority population and/or a crisis situation. Individuals identified as a priority population who request or are referred to treatment must be assessed and admitted to an appropriate level of care within 48 hours of initial contact or scheduled release date, whichever is later. Otherwise, the provider must initiate interim services. Pregnant women and civil involuntary commitments, however, require immediate admission. Pregnant women are to be referred to a CSTAR Women and Children Program unless there is clinical justification to admit her to a general treatment program.

DBH's SATOP program is a statewide system of comprehensive, community-based education and treatment programs designed for individuals who have pled guilty or were found guilty of an impaired driving offense with administrative action. SATOP is also required for offenses for individuals under the age of 21, charged with Minor in Possession, Abuse and Lose, and Zero Tolerance offenses. The program serves an average of 17,000 individuals annually. The mission of SATOP is to: A) inform and educate DWI offenders as to the hazards and consequences of impaired driving; B) educate youth about the risks and consequences of alcohol and drug use and help them develop skills to make healthy choices; C) motivate individuals for personal change and growth; and D) contribute to the public health and safety of Missourians by preventing and reducing the prevalence of alcohol and drug impaired driving. DBH certifies and monitors SATOP programs which offer varying levels of intervention. In order for an individual to complete SATOP requirements one must complete a drug and alcohol assessment, pay fees, and successfully complete the assigned level of education or clinical treatment services. Many factors are considered for program placement, which include: drug and alcohol history and previous substance use treatment; previous DUI/DWI history; Blood Alcohol Content (BAC) at time of arrest; and a determination of whether an individual meets diagnostic criteria for a substance use disorder. SATOP is largely funded by SATOP fees.

Core services for the Division of Behavioral Health's (DBH) Community Psychiatric Rehabilitation Program (CPR) (26 contracts), targeted case management (17 contracts), and supported community living are provided in a community-based and consumer-centered manner. Services provided in DBH's Community Psychiatric Rehabilitation Program (CPRP) for adults (26 contracts) and children/youth (21 contracts) are Medicaid reimbursable. The types of services provided in the CPR program include evaluation, crisis intervention, community support,

medication management, and psychosocial rehabilitation. Outpatient community-based services provide the least-restrictive environment for treatment. Day treatment offers the least-restrictive care to individuals diagnosed as having a psychiatric disorder and requiring a level of care greater than that provided in outpatient services but not at a level requiring full-time inpatient services. Day treatment may include vocational education, rehabilitation services, and education services. Moderate-term placement in residential care provides services with non-acute conditions who cannot be served in their own homes. Intensive CPR programs include Enhanced Psychosocial Rehabilitation (PSR), Assertive Community Treatment (ACT), Assertive Community Treatment for Transition Age Youth (ACT-TAY), Integrated Treatment for Co-Occurring Disorders (ITCD), Clustered Apartments, Intensive Residential Treatment Services (IRTS), Psychiatric Individualized Supported Living (PISL), and Inpatient Diversion. Individuals whose psychiatric needs cannot be met in the community and who require 24-hour observation and treatment are placed in inpatient treatment. These services are considered appropriate for individuals who may be a danger to themselves or others because of their mental health. DBH also oversees Community Mental Health Treatment (CMHT) and Offenders with Serious Mental Illness (OSMI) (28 contracts) for Department of Corrections' (DOC) offenders under community supervision and who have mental illness. Mental health treatment is prioritized for individuals who:

- Have been discharged from inpatient psychiatric hospitalization programs within the last ninety (90) days;
- Are residents of supervised or semi-independent apartments, psychiatric group homes, or community residential programs;
- Have been committed by court order under provisions of section 632.385, RSMo;
- Have been conditionally released under section 552.040, RSMo;
- Are homeless or considered homeless in accordance DBH criteria;
- Are having a current episode of acute crisis or being referred from the crisis system;
- Have used a hospital emergency room related to a psychiatric illness two or more times during the prior year;
- Have attempted suicide;
- Are high utilizers of Medicaid services with co-occurring behavioral health and other chronic health conditions; and
- Children and adolescents at risk of disruption from a preferred living environment due to symptoms of a serious emotional disturbance.

DBH supports Assertive Community Treatment (ACT), a service-delivery model that provides comprehensive, community-based treatment to people with serious and persistent mental illnesses who: 1) are high users of inpatient beds, 2) often have co-occurring substance use diagnoses, 3) have involvement with the criminal justice system, and/or 4) are homeless. ACT provides highly individualized, intensive services directly to consumers in their homes and communities as opposed to a psychiatric unit. ACT team members are trained in the areas of psychiatry, social work, nursing, substance use, and vocational rehabilitation. DBH contracts with nine agencies to provide ACT including nine teams for adult ACT and twelve teams for ACT for Transitional Age Youth (ACT-TAY) and four specialized teams for parents with children at risk of custody removal. DBH contracts with three agencies to provide Parent Child Specialty Teams focused on parental substance use rehabilitation and preventing infants/young children from entering foster care system. There are four Parent Child Specialty Teams in Missouri. These teams

engage and address mental health and co-occurring needs of mothers who are diagnosed with a severe mental illness and who are pregnant and substance-using or have recently given birth to a child who tested positive for substances at the time of delivery or they are parenting young children. This team based intensive treatment intervention follows meets the unique needs of pregnant women or new parents and their children by implementing a treatment response that is clinically fashioned to address the parent and children's needs during pregnancy, birth and the postpartum period and early childhood years. Services are available twenty-four hours a day, seven days per week with evening and weekend service opportunities available to the mothers and children when needed. The teams have capacity to provide treatment to the family unit and to increase the parent-child bond and improve family relationships. This treatment model is based on the ACT model but modified to support these young adult parents in individual and family therapy, treatment for co-occurring disorders, first episode psychosis, supported education and vocational support, nursing services and peer specialist interventions.

In 2022, DBH formed the Early Psychosis Care (EPC) Center which is a best practice center providing education and technical support to CCBHOs and other community stakeholders that provide support and services to individuals experiencing their first episode of psychosis (FEP) and to impacted family members. In 2023, two CCBHOS plan to form and implement First Episode Psychosis- Coordinated Specialty Care (FEP-CSC) teams at their agencies. FEP-CSC is an evidence based practice supporting individuals experiencing their first episode of psychosis. CSC Teams work to provide early identification and team based interventions in order to reduce symptom severity and shorten the duration of untreated psychosis.

DBH supports Integrated Treatment for Co-Occurring Disorders (ITCD), an evidence-based program treating adults for severe and persistent mental illness and substance use disorders. Services are provided by a multidisciplinary treatment team in the home or community as well as within the agency. Team members include prescribers, RNs, integrated treatment counselors and case managers all specifically trained in co-occurring treatment. ITCD services are evaluated for fidelity to the ITCD model by the department. DMH contracts with 28 community mental health agencies providing ITCD services at 50 locations.

For mental health treatment, the state is divided into 25 mental health service areas each with an Administrative Agent. By Missouri statute, these Administrative Agents are responsible for the assessment and provision of services either directly or through affiliate Community Mental Health Centers (CMHC) for individuals residing in the assigned service areas. The Administrative Agents are also required to have cooperative agreements with the state-operated inpatient hospitals and are responsible for the provision of follow-up services for persons released from the state or private psychiatric hospitals. Of the 28 CMHC's, 26 are also contracted for Health Homes which was implemented in January 2012. Of the 26 Health Homes, 22 are Certified Community Behavioral Health Organizations (CCBHO) who participated in the CCBHC Prospective Payment System Demonstration Project.

CCBHOs integrate behavioral health with physical healthcare, while providing a comprehensive array of services that include crisis intervention, screening, treatment, prevention, peer and family support services, and wellness services for individuals with serious mental illnesses and substance use disorders. CCBHOs are designed to demonstrate the cost effectiveness of converting to a prospective payment system while improving the availability, accessibility, and

quality of community behavioral healthcare. The Prospective Payment System (PPS) is an actuarially sound cost-based reimbursement method that replaces the current Medicaid fee-for-service system, which provides reimbursement for individual units of community service provided. CCBHOs recognized by the DMH in substantial compliance with federal and state standards for CCBHOs receive a single, fixed payment amount for each day that they provide eligible CCBHO services to a Medicaid-eligible individual. Missouri currently has 22 CCBHOs that are participating in the federal demonstration covering all of Missouri's 114 counties.

For substance use treatment, individuals' access services directly from the contracted service provider and may seek services anywhere in the state regardless of their county of residence. DBH funds 10 regional Access Crisis Intervention Hotlines that are staffed by mental health professionals 24 hours per day and 7 days per week to provide intervention and referral for individuals experiencing a behavioral health crisis. DBH has arrangements with local taxing authority boards who have a Mental Health Mil tax or Children's Services tax to fund mental health services for adults (three counties plus the city of St. Louis) and youth (four counties) and substance use treatment for adults (three counties) and youth (two counties plus the city of St. Louis). Regional offices provide consultation and technical assistance to community-based service providers and conduct regular reviews of provider systems.

DBH has implemented several programs to improve coordination of consumers' primary and behavioral healthcare. Disease Management 3700 started as a two-year collaborative demonstration project between DBH and the state Medicaid authority, MO HealthNet. Medicaid eligible individuals with serious and persistent mental illness, who are not current consumers of DMH, and who have had a minimum of $20,000 annual Medicaid claims are identified for the program. Individuals successfully outreached and engaged through the project are enrolled in a CMHC, CCBHO or SUD treatment provider and assigned a Community Support Specialist. The Disease Management program served as a model for Missouri's Health Home initiative and the Substance Use Disorder (SUD) Disease Management. The SUD Disease Management program began in February 2014 and targets Medicaid-enrolled adults with substance use disorders and high medical costs who are not currently engaged in treatment.

The Community Mental Health Centers (CMHCs) and Federally Qualified Health Centers (FQHCs) Integration Initiative allows CMHCs and FQHCs to partner. The goals of the Integration Initiative supports collaboration between CMHCs and FQHCs to integrate behavioral health services and primary care in the public health safety net system in order to improve access to: primary care for individuals with mental illness; behavioral health services for individuals with previously unrecognized and/or untreated mental health problems; and behavioral health supports for individuals who require assistance in effectively managing their chronic disease or improving health status.

The SUD Provider and FQHC Integrated Care Project allows Behavioral Health Providers contracted by DBH to provide CSTAR services and FQHCs to partner. The goals of the project support collaboration between FQHCs and DMH certified CSTAR Providers to integrate primary care and substance use treatment in the public health safety net system in order to: identify substance use concerns within the primary care environment; reduce health disparities; and change improve, create the working relationship between primary medical and specialty behavioral health.

Missouri has two types of healthcare homes: 1) the behavioral health including CMHCs and CCBHOs, and 2) primary care including the Federally Qualified Health Centers, Rural Health Clinics, and Hospital-Operated Primary Care Clinics. Enrollment in the CMHC/CCBHO Health Homes began in January 2012. Eligible individuals must be covered by MO HealthNet and have 1) a serious and persistent mental illness, 2) a mental health condition and a substance use disorder, or 3) a mental health condition or a substance use disorder and a chronic health condition. Of those enrolled, approximately 81% are adults and 19% are children or youth. As a Health Home, the CMHC/CCBHO's provide comprehensive case management, care coordination and health promotion, patient and family support, comprehensive transitional care, and referrals to community and support services.

DMH also funds initiatives through the Missouri's Strengthening Mental Health Initiative aimed at reducing the unnecessary use of emergency departments for behavioral health issues and to assist law enforcement and courts to more efficiently connect individuals with behavioral, physical and basic needs services. Emergency Room Enhancement (ERE) initiative provides funding to 18 regions of Missouri to reduce repeated use of emergency departments and hospitals for behavioral health concerns that would be better addressed in community settings. The 18 regions include Kansas City, Springfield, Columbia, Hannibal, St. Joseph, St. Louis, Rolla, Poplar Bluff, Joplin, Cape Girardeau, Jefferson City, Monett, Trenton, West Central, West Plains and as of 2022-2023 the newest regions are Bootheel, East Central and Farmington. ERE is now available in all 114 of Missouri's counties. Each of these areas have partnered with local hospitals, community mental health centers, law enforcement agencies, substance use treatment providers, and social service providers to coordinate care for the whole person by addressing behavioral, physical and basic needs. The Community Behavioral Health Liaison (CBHL) initiative originally consisted of 31 CBHLs, but due to the tremendous success of the program, 50 additional positions were added in 2021. CBHLs are employed by behavioral health provider organizations across the state to assist law enforcement and courts to form better community partnerships between treatment providers, law enforcement, jails, and courts. This programs saves valuable resources that might otherwise be expended on unnecessary jail, prison, and hospital stays, and improve outcomes for individuals with behavioral health issues. Liaisons also follow-up with Missourians referred to them in order to track progress and ensure success. Through the CBHL program, individuals with behavioral health issues who have frequent interaction with law enforcement and the courts will have improved access to behavioral health treatment. The Missouri Crisis Intervention Team (CIT) program is a partnership with law enforcement and other first responders, behavioral health providers, hospitals, courts, individuals with lived experience, and community partners. The goal of CIT is to promote more effective law enforcement interactions with individuals in crisis, connect individuals in crisis with available resources, improve safety of the first responder and the individual in crisis, reduce stigma, and expand and sustain CIT across the state. There are 34 local CIT Councils in 108 out of 114 of Missouri's counties.

The Youth Behavioral Health Liaisons (YBHL) initiative originally consisted of one YBHL in the Eastern Region within the CBHL network in 2015. A new decision item was approved by Governor Parson in 2022 funding four additional YBHL positions. In 2023 general revenue funding was approved to support 27 YBHL positions, which allowed state-wide coverage. YBHLs are distributed among the community behavioral health organizations across Missouri to form better community partnerships between behavioral health services, schools, Children's Division, juvenile office, family court, law enforcement, and other children/youth-serving state agencies.

There have been 4,182 youth referred to date, 30% were from law enforcement, 81% referred to mental health services.

Psychiatric Facility Operations

Facility Operations includes management and oversight of the six state-operated psychiatric facilities – one for children and five adult hospitals. With limited exceptions, state operated facilities for adults provide hospital treatment for individuals referred by the criminal courts for competency restoration and as Not Guilty by Reason of Mental Disease or Defect or referred by the probate court as Missouri's Sexually Violent Predator Act. Adult facilities are located in St. Louis, St. Joseph, Fulton, Kansas City, and Farmington. The youth facility is located in St. Louis. Currently, there are 890 adult psychiatric inpatient, 57 adult psychiatric residential, 28 child and youth psychiatric inpatient, 16 youth psychiatric residential, 287 sexual offender inpatient, and 16 sexual offender residential beds.

Forensic services provides evaluation, treatment, competency restoration, and community monitoring under the order of the circuit courts for individuals with mental illness and developmental disabilities involved in the criminal justice system. DBH provides three levels of security (high, minimum, and campus), with the desired goal of progressive movement through the security continuum based on clinical condition and risk assessment. Within this continuum, forensic clients are provided treatment in a setting consistent with both the clinical needs of the consumer and safety of the public. Long-term forensic treatment programs are located at Southeast Missouri Mental Health Center, St. Louis Forensic Treatment Center - South, Northwest Missouri Psychiatric Rehabilitation Center, and Fulton State Hospital. Forensic Case Monitors provide community monitoring, as required by state statute, to forensic consumers acquitted as not guilty by reason of mental disease or defect who are given conditional releases by circuit courts. There are approximately 400 forensic consumers on conditional release statewide.

Children's Services

Both substance use and mental health services for children are coordinated between the DMH Children's Director and DBH program staff. Community Psychiatric Rehabilitation (CPR) provides a range of essential mental health services to children and youth with serious emotional disturbance (SED). These community-based services are designed to maximize independent functioning and promote recovery and self-determination. A statewide assessment tool quickly identifies where outcomes are needed so clinicians/community support specialists can address those areas on the individualized treatment plan with the goal of improved functioning and symptom reduction. An assigned Community Support Specialist monitors medical, dental, and support service needs and coordinates services and resources among community agencies. The CPR program includes an intensive level of care for acute psychiatric episodes as clinically appropriate. Approximately 80% of the youth receiving mental health treatment are in the CPR program. Community support services available to children and youth include day treatment, psychosocial rehabilitation services, intensive/non-intensive targeted case management, community support, respite, family support, and family assistance. Day treatment provides goal-oriented therapeutic services focusing on the stabilization and management of acute or chronic symptoms, which have resulted in functional deficits. Day treatment may include physician services, psychiatric evaluations, medication management, age appropriate education services, skill building groups, individual and group psychotherapy, occupational/physical therapies, community support, and family support. Psychosocial

rehabilitation services are a combination of goal-oriented and rehabilitative services provided in a group setting. Family support helps establish a support system for parents of children with SED. Activities may include, but are not limited to, problem solving skills, emotional support, dissemination of information, linkage to services, and parent-to-parent guidance. With family assistance, a Family Assistant Worker may work with the individual and family on home living and community skills, communication and socialization, and conflict resolution.

In 2020, the youth peer support service was added to the CPR Program. Youth Peer Support Specialists support, encourage, and model positive self-advocacy, recovery and resiliency. The DBH requires all Youth Peer Support Specialists providing services to youth under the age of 18 to be certified in youth peer support. A nationally recognized training curriculum is utilized and a competency exam is required.

In 2012, Professional Parent Home (PPH) services were added to the CPR array of services offered to children and youth. The children and youth served in PPH have serious emotional needs which often result in behaviors that precipitate placement in restrictive residential or inpatient settings. PPH exists to serve these children and youth in a private home designed to be a therapeutic environment to avoid such restrictive placement. PPHs consist of trained and qualified professionals serving only one child/youth at a time in their home, due to the severity of the child/youth's needs. The parenting role is the sole employment for these parents. They are required to complete 40 hours of basic training as well as an enhanced training package. These children/youth have demonstrated an inability to be in the community free of emotional or physical difficulty and who, without a sustained intensive therapeutic intervention, would have significant physical, emotional, or relational consequences. PPH providers are responsible for participation in the development of the child/youth's treatment plan and record documentation related to implementation of the treatment plan within the home. Treatment Family Homes (TFH) are a less restrictive version of the PPH model. Up to three children/youth may be placed in each TFH and, TFH parents are trained and qualified individuals who work with youth in their own home. The goal of this service is to reunite youth with their families whenever possible.

In 2013, DBH offered an introductory training to providers across the state on a specialized Assertive Community Treatment (ACT) service targeted for the transitional age youth (ages 16-25) population. The first Missouri Assertive Community Treatment Transition Age Youth (ACT TAY) program was developed in the Central Region and began providing services to this population in January 2014. The ACT TAY program uses a team approach designed to provide comprehensive and flexible treatment, support, and rehabilitation services to transition age youth in their natural living settings rather than in hospital or clinic settings. The multi-disciplinary team members include a physician, nurse, vocational specialist, substance use specialist, peer specialist, and community support specialist. Missouri has 10 ACT TAY programs.

For children and youth, the first signs of mental illness or emotional distress can emerge in the school environment. DBH has expanded the availability and accessibility of treatment services by authorizing the delivery of designated CPR services in school settings. These designated CPR services are provided to children and youth with an Individualized Education Plan (IEP) or a 504 plan as well as children and youth without a formal plan who are determined to need additional support due to behavioral health issues. DBH providers partnering with schools is effective because it enables behavioral health specialists to quickly identify student issues and immediately

triage care based on the severity of circumstances. In addition to students getting immediate assistance, school personnel benefit from having CPR services provided in the school setting.

Substance use treatment for youth is provided in the CSTAR Adolescent program. Designed for youth age 9 to 17, the CSTAR Adolescent program offers a full array of treatment services. Treatment focuses on issues relevant to this age group and is provided in settings that are programmatically and physically separate from adult programs. Youth in residential settings, ages 12-17, are offered academic support services to minimize disruptions in their education. For youth with co-occurring mental health and substance use disorders, treatment services are provided through coordination of care between youth CPR and CSTAR adolescent programs. Multiple domains of the youth's life are addressed including family, school, employment and social support. The Assertive Community Treatment for Transitional Age Youth (ACT TAY) model for ages 16-25, utilizes a trans-disciplinary approach to provide a comprehensive array of services to address both mental health and substance use.

The DMH is partnering with the Department of Social Services (DSS) to support the successful roll out and implementation of the Family First Preservation Services Act in Missouri. The federal child welfare legislation passed in 2018 and implemented in Missouri in October 2021, was designed to enhance prevention services and help children remain safely in their homes to avoid the traumatic experience of being separated from their family. One component of this transformative legislation requires that an independent assessment must be completed by a qualified clinician for youth entering DSS custody to determine if the youth's needs could be met with community-based services while living with a relative or resource family, or if residential treatment is the most effective and appropriate short-term placement. DBH providers partnered with DSS to establish "Independent Assessors" within each Judicial Circuit, with the goal of keeping community-based services as close to youth and caregivers as possible. DBH providers will also centrally track the referrals, assessments, and outcomes for this process.

The DMH continues to partner with the Department of Social Services (DSS) to provide resources and options to parents who are considering voluntarily relinquishing custody for the sole purpose of accessing mental health treatment for their child/youth. For those children/youth already in state custody solely for mental health services in the absence of child abuse or neglect and severe intellectual/developmental disability, DMH and DSS have facilitated an evaluation and review process. DSS' Children's Division has established Family Support Teams for children identified to determine future custody status. In conjunction with the diversion protocol, voluntary placement under Title IV-E allows a family to relinquish physical custody but retain legal custody so that these children/youth become eligible for mental health services funded by Medicaid and Title IV-E funds for a period of up to 180 days. System of Care Expansion Grant funding from SAMHSA has supported the expansion of local interagency teams to oversee children's services in the community and promote earlier identification and intervention services. Missouri currently has 39 local System of Care (SOC) teams.

Recovery Supports

The Division of Behavioral Health's (DBH) Recovery Services includes housing, employment, peer and family services, Recovery Support Services (RSS), and coordination of the DBH State Advisory Council. The Director of Recovery Services oversees DBH's housing unit that connects homeless individuals who are challenged with behavioral health issues with safe,

decent, and affordable housing options that best meet their individual and family needs. In addition to providing education and technical assistance, DBH's housing unit manages 27 U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) Permanent Support Housing (PSH) grants that provides rental assistance for individuals who 1) are homeless, 2) have a serious mental illness, a chronic substance use problem, a severe and chronic developmental disability, or a diagnosis of HIV/AIDS, and 3) meet the "very low" income requirement. Approximately 3,000 persons are served annually through Missouri's Shelter Plus Care program. Missouri has ten federally-funded Projects for Assistance in Transition from Homelessness (PATH) grants to support service delivery to adults (age 18 or older) with serious mental illness, as well as those with co-occurring substance use disorders, who are homeless or at risk of becoming homeless. The state prioritizes the following PATH activities: outreach, case management, referrals, and housing services to fill gaps in existing services for PATH eligible clients. Missouri allocates its PATH funding to CCBHO/CMHCs with consideration for other entities as appropriate. PATH funds are distributed across Missouri with priority to areas with the highest concentrations of literally homeless persons. Funding may be allocated proportionally to the amount of literal homelessness in the geographic area based upon five year trends in Point In Time Count (PITC).

Missouri is covered by 8 Continua of Care which are the HUD mandated planning bodies for homeless services. PATH services are integrated into the work of the Continua of Care in which they operate to ensure that PATH services and PATH clients are connected to the local homeless response system. This integration ensures that PATH clients, who are highly vulnerable and often have high barriers are connected to all possible housing options and other services. Examples of integration at the PATH program level include participating in CES, participating in outreach initiatives, and being an engaged and active member of the Coc. DMH staff are also extremely involved in CoC efforts, attending 62 monthly CoC meetings and holding 16 leadership positions across CoCs. Additionally, DMH provides support to and holds leadership positions with the Missouri Interagency Council on Homelessness.

DBH also has funds set aside for Rental Assistance Program and Disease Management Housing funds. Both funds are emergency housing funds to keep people housed or get them set up in safe housing. DBH has a Housing, Employment, Recovery Opportunities (HERO) program that provides housing and intensive clinical treatment to 63 Veterans monthly in our St. Louis area funded by Veterans Administration. DBH partnered with Department of Economic Development to bring in $2,577,707 in HUD funds to Missouri for the Show Me Recovery Housing Program providing housing and utility assistance to persons in recovery.

Supported community living funds are provided for persons with mental illness who do not have a place to live or who need more structured services while in the community. Persons in these programs receive support through community psychiatric rehabilitation programs provided by CCBHO/CMHCs.

Housing Liaison (HL) positions launched in 2021 in the CPR/CSTAR programs using Block Grant Supplemental Funds with 47 HLs across Missouri. These positions assist Missourians with disabilities experiencing unsheltered homelessness. All referrals come from local coordinated entry systems. HLs reduce the use of more costly state services, shifting use to less costly, more appropriate services by:

- Developing local resource guides;
- Outreaching persons experiencing unsheltered homelessness;
- Assisting clients with obtaining permanent housing;
- Assisting clients with enrolling in ongoing treatment;
- Assisting clients with increasing cash income;
- Increasing number of landlords willing to rent to clients; and
- Creating local landlord lists.

DBH recognizes the tremendous therapeutic value of employment for working-age individuals with behavioral health disorders and is committed to enhancing employment options for those individuals. Supported Employment is an evidence-based practice that provides individualized services and supports to an individual in competitive employment to promote stable employment. Missouri uses the Individualized Placement and Support (IPS) model to fidelity. DBH works with the Department of Elementary and Secondary Education, Vocational Rehabilitation (VR) who provides job counseling, job-seeking skills, job placement, and vocational training. DBH also provides support services for behavioral health clients not currently eligible or ready for services from VR. The Department of Mental Health (DMH) provides ongoing benefits planning training materials and a web-based tool "Disability Benefits 101". DBH staff developed guidance documents on appropriate community support interventions reimbursable under the CPR and CSTAR treatment programs for consumers pursuing employment (DMH, 2012). DMH has 33 community behavioral health locations designated as VR funded Community Rehabilitation Programs to provide evidence based supported employment services. Employment Specialist services and training are provided in the ICTS programs, RSS, and Recovery Community Centers.

In 2018, DBH began certifying Recovery Support Services providers for care coordination, peer recovery coaching, spiritual counseling, group support, recovery housing and transportation before, during, after and in coordination with other substance use disorder service providers. These services are offered by 60 certified/contracted Recovery Support Service providers in a multitude of settings including community, faith-based and peer recovery organizations. Recovery Support programs are person-centered and self-directed. Recovery Housing certification requires the provider to also obtain accreditation through the Missouri Coalition of Recovery Support Providers/National Alliance of Recovery Residences (NARR). Currently, 188 Recovery Houses with over 2124 beds are accredited. DMH receives a SAMHSA State Opioid Response (SOR) grant for the purpose of expanding access to integrated prevention, treatment, and recovery support services for individuals with opioid use disorder throughout the state, including development of local Recovery Community Centers (RCC). Four RCCs provide a peer-based supportive community that builds hope and supports healthy behaviors for individuals with Opioid Use Disorders (OUD) and Stimulant Use Disorders searching for or maintaining recovery. Four additional RCCs are funded with Block Grant Supplemental Funds. Peer Respite Crisis Stabilization is a new service contracted for with both Block Grant Supplemental Funds and SOR Grant funds. Six providers are piloting this new peer based crisis service.

Peer support services are delivered by individuals who have been successful in recovery from mental and/or substance use disorders who help others experiencing similar situations. Through shared understanding, respect, and mutual empowerment, peer support services help people become and stay engaged in the recovery process and reduce the likelihood of relapse. Peer

support services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustained recovery process. Missouri currently has over 1,500 actively Certified Peer Specialists whom work at CCBHOs, Community Mental Health Centers, Substance Use Treatment Programs, state-operated hospitals, recovery support services, RCCs, EPICC, ERE, BHCC, mobile crisis response, and a multitude of other programs. Family Support Provider is a peer to peer service that provides support to parents/caregivers who have children with SED and SUD. Activities may include, but are not limited to, problem solving skills, emotional support, dissemination of information, linkage to services, and parent-to-parent guidance.

DBH funds through competitive bid four Consumer Operated Service Programs (COSP) Drop-In Centers. COSPs are peer-run service programs that are administratively controlled and operated by individuals in recovery from mental health issues and emphasize self-help as their operational approach. Drop-In Centers are a safe place where individuals can go to find recovery programs and services provided by their peers. They offer a wide variety of services including recovery focused support groups, life enhancement skills, goal setting, problem solving, computer and internet access as well as socialization with others in recovery. Anyone with a mental health diagnosis or who is or has experienced symptoms of a mental illness is welcome to participate in services. All services are self-directed and free of charge. DBH contracts for one statewide Peer Phone Line offering safe, confidential telephone support provided by peers in recovery from mental illness. Peer responders are available to assist individuals with non-crisis mental health issues. They provide assistance in problem solving, goal setting, conflict resolution, and coping skills. They also provide resources and referrals to other agencies providing services including housing, food banks, transportation, professional counseling and crisis management.

DBH contracts with National Alliance for Mental Illness (NAMI) Missouri to provide statewide Family-to-Family Support Groups, NAMI Basics, Ombudsman services, and NAMI Provider Education Program trainings.

The Mental Health Planning Council for the DBH is an integrated State Advisory Council (SAC). The DBH SAC includes two standing committees, the Mental Health Disorders Committee and the Substance Use Disorders Committee. The purpose of these committees is to ensure adequate representation and focus on the issues unique to each committee. The co-chairpersons of these standing committees equally share the leadership of the full SAC. Meetings typically include budget and programming updates from DBH staff as well as in-depth presentations and discussions on initiatives and strategic planning. Members have professional, research, and/or personal interests in the respective area. Membership on the SAC must be at least one-half individuals with lived experience of recovery and/or family members and have at least one member representing veterans and military affairs. Current membership includes representation from the Departments of Social Services, Medicaid, Corrections, Vocational Rehabilitation, Education, Housing, Mental Health, Health and Senior Services, vendors, and people with lived experiences. At the April 2023 meeting SAC members reviewed a draft of the FY 2024 – 2025 MH-SUPTRS Block Grant Application. At the June 7 SAC meeting the Block Grant Plan and approval letter were discussed, voted on and approved as presented. The approval letter was signed.

Prevention and Mental Health Promotion

Prevention and Mental Health Promotion includes substance use prevention, opioid overdose prevention, tobacco retailer education, Mental Health First Aid, veteran's services, suicide prevention, and crisis services. DBH contracts with 10 community-based Prevention Resource Centers (PRC) that are state-certified to provide prevention services on alcohol, tobacco, and other drug issues. The PRC's are the primary source of training and technical assistance support for over 165 community coalitions located throughout the state. The coalitions are teams of volunteers of community leaders, parents, and youth who seek to address substance use in their communities. The PRC's employ prevention specialists that serve as community-level experts to assess community needs, build capacity, develop strategic plans, and implement evidence-based prevention programming. Opioid overdoses have greatly impacted Missouri, especially in the St. Louis region. DBH has received federal grants from SAMHSA to provide prevention, treatment, and recovery services in response to the Opioid Crisis.

The Director of Prevention and Crisis Services is also the project coordinator for the state's FDA tobacco enforcement contract. The PRC's provide retailer education on state and federal tobacco regulations to local tobacco retailers and assist the state in compiling a list of tobacco retailers in support of federal Synar requirements, as Missouri does not have tobacco licensure. DBH subcontracts with the Department of Public Safety, Division of Alcohol and Tobacco Control for enforcement of the federal Family Smoking Prevention and Tobacco Control Act. DBH also provides funding to Partners in Prevention (PIP), Missouri's higher education substance use consortium representing 25 colleges and universities and serving about 200,000 college students. PIP administers the Missouri Assessment of College Health Behaviors (MACHB) which is completed by approximately 6,000 students each school year. The PRC's, PIP, and many community coalitions have been trained on and use SAMHSA's Strategic Prevention Framework planning process. In support of prevention planning at the local level, DBH funds the biennial Missouri Student Survey (MSS) to assess substance use and related behaviors among students in grades 6th through 12th.

DBH's School-based Prevention, Intervention, and Resources Initiative (SPIRIT) implements school-based curricula of proven effectiveness for reducing substance use, preventing substance initiation, and reducing violent behavior among children and youth in kindergarten through 12th grade. Age- and grade-appropriate programs are selected from SAMHSA's National Registry of Evidence-based Programs and Practices. SPIRIT currently operates in four sites serving 13 school districts across the state. These school districts serve high-risk populations characterized by: 1) high percentage of students qualifying for reduced/free lunches, 2) low standardized test scores, 3) high prevalence of substance use, 4) low graduation rates, and/or 5) high rate of juvenile justice referrals. Screening and referral services are provided. In FY 2023, about 9,779 students participated in the SPIRIT program. DBH contracts with the Missouri Institute of Mental Health to conduct an annual evaluation of the SPIRIT program.

DBH also funds other selective prevention services and early intervention activities for designated children, youth, and families. These services involve structured programming and/or a variety of activities including informational sessions and training. Target groups include youth experiencing academic failure and low-income youth and families. Programs are located in Kansas City, St. Louis, Greene County, Branson, Rolla, and the seven-county area in southeastern Missouri known as the "Bootheel". DBH contracts with the Missouri Alliance of Boys and Girls

Club sites throughout the state for implementation of SMART Moves (Skills Mastery and Resistance Training) and MethSMART. In Fiscal Year 2023, 4,440 high risk youth were served in prevention programs funded through DBH. DBH contracts with DeafLEAD for the provision of prevention services for deaf and hard of hearing youth. DeafLEAD conducts two one-day events that interact with the youth and focuses on prevention and education activities. The events are attended by approximately 30 youth ages 13 to 19.

In 2010, Missouri established an interagency Statewide Epidemiology Outcomes Workgroup (SEOW) through funding support from SAMHSA. Missouri's SEOW is chaired by an Epidemiologist at the Missouri Institute for Mental Health – University of Missouri, St. Louis. The core group comprises of the four epidemiologist funded through the state (1) and community (3) Partnership for Success grantees. Additional feedback is gathered from the Department of Mental Health and other stakeholders as appropriate. Missouri's SEOW mission is to:

- Create and implement a systematic process for gathering, reviewing, analyzing, integrating, and monitoring data that will delineate a comprehensive and accurate picture of behavioral health issues in the State and its communities;
- Inform and guide behavioral health prevention policy, program development and evaluation in the State; and
- Disseminate information to State and community agencies, targeted decision-makers, and the general public.

DBH partners with the National Council for Mental Wellbeing and the Missouri Institute for Mental Health to implement Mental Health First Aid (MHFA). MHFA is a program that teaches the public how to recognize the signs and symptoms of mental health problems. Over 47,000 individuals have taken the MHFA adult course in Missouri, 29,000 adults who work with youth have received MHFA youth training, and 170 individuals have been trained in MHFA. An instructor course is also available for individuals seeking instructor certification. Over 450 individuals have been certified as MHFA instructors in Missouri.

With federal grant funding, DMH has been able to increase suicide prevention efforts in the state. Efforts have included Zero Suicide and other evidence-based trainings, school and emergency room interventions, and statewide public education for adults and youth. In 2018, DBH partnered with the Missouri Behavioral Health Council to create the Missouri Suicide Prevention Network to lead and coordinate statewide suicide prevention efforts. In 2021, Missouri Suicide Prevention Network updated Missouri's State Suicide Prevention Plan. The three priorities of the State Suicide Prevention Plan are to fully embrace a public health approach to suicide prevention, establish Missouri as a Zero suicide in Healthcare state and develop a robust data collection and reporting system.

In 2012, DMH hired a Project Manager to oversee behavioral health services for Missouri's veteran population. The Veteran's Services Director manages the statewide policy development, implementation, and operation of supportive services for service members, veterans, and their families. This includes coordinating federal (Veterans Administration), state agencies, and community behavioral health programs ensuring the military community (service members, veterans, and their families) has access to timely, quality services. The position analyzes behavioral health systems, develops strategies, program development, project management and administrative of behavioral health supportive services; workforce

development; raising public awareness of the military community's needs, and educating Missourians on how to connect with appropriate services. Missouri is one of 54 states and territories participating in the Governor's Challenge to Prevent Suicide Amongst Service Members, Veterans, and their Families. DBH created a state team consisting of federal, state, and community partners working to develop and implement state-wide suicide prevention best practices for Service Members, Veterans, and their Families, using a public health approach. This national initiative is a partnership through SAMHSA and the U.S. Department of Veterans Affairs (VA). DBH is supporting the Missouri National Guard in changing how they deliver prevention/intervention programming for individuals who are making high-risk alcohol and drug related choices. Now offering the *MyPrime* online psychoeducation that deters substance use based on the previous in person program on the NREPP called *Prime For Life*.

DBH has made considerable strides in aligning our crisis system with SAMHSA's guidelines and best practice considerations for crisis services. DBH echoes the sentiment that crisis services should be available to anyone, anywhere, and at any time. To achieve a comprehensive crisis continuum that is equipped to meet the needs of individuals throughout the state, we are prioritizing the enhancement, alignment, and coordination of these community crisis components:

- The 988 Suicide & Crisis Lifeline and Access Crisis Intervention Services (*Someone to talk to*)
- Mobile Crisis Response Services (*Someone to respond)*
- Crisis Receiving and Stabilization Services (*Someplace to go*)

National mental health leaders recognized the overwhelming need for people experiencing a mental health crisis to connect to services more easily. 988 was designated as the national three digit phone number for individuals experiencing a mental health, suicide, or substance use crisis. By dialing 988, individuals in crisis will quickly be routed to a trained crisis specialist who will provide in-the-moment support and connection to services and resources. DBH received a state planning grant to prepare for 988 rollout on July 16, 2022, and the years following. Over the past few years, Missouri has expanded its National Suicide Prevention Lifeline members from three to six, with an additional member pending. These centers will be responsible for handling all 988 calls, chats, and texts that occur in the state. Missouri is leading a 988 Task Force that is made up of behavioral health leaders and advocates who are coming together to plan and prepare for 988 implementation. Planning elements include meeting, maintaining, and improving capacity, funding, and infrastructure to achieve better outcomes for Missourians in crisis. With 988 highlighting the opportunity for expansion of crisis care in Missouri, DMH is partnering with the Missouri Behavioral Health Council and other stakeholders to achieve operational, clinical, and performance consistency to ensure significant connection and continuity of care across the state. Missouri stakeholders are placing particular emphasis on attaining a more equitable and community-oriented crisis response by responding to wherever the crisis occurs.

DBH also funds 10 regional Access Crisis Intervention (ACI) Hotlines that are staffed by mental health professionals 24 hours per day and 7 days per week to provide intervention and referral for persons experiencing a behavioral health crisis. Providers currently provide mobile crisis response services. Mobile Crisis Response services are available to individuals of all ages who are experiencing a mental health, suicide, and/or substance use crisis; or who are experiencing

a high level of personal distress. Mobile Crisis Response services are available regardless of Medicaid enrollment, insurance status, place of residence, or ability to pay. Mobile Crisis Response services should be responsive to people's cultural, linguistic, gender, sexual orientation, disability, and developmental needs. Mobile Crisis Response Teams shall be available in-person 24-hours, 7 days a week, 365-days a year, in sufficient quantity within the Service Area to respond to crises.

Behavioral Health Crisis Centers (BHCCs) in Missouri serve as an appropriate alternative to hospitalization or jail. BHCCs provide prompt assessment, medical monitoring, stabilization, determination of the next level of care needed, and links individuals to resources and treatment in a trauma-informed setting. BHCC regulations were established and became effective June 30, 2023. There are 18 operational BHCCs in Missouri, and state appropriations were approved to construct four additional BHCCs in FY24.

Disaster Services

DMH's Office of Disaster Services (ODS) conducts planning and development activities to support a coordinated mental health response for Missourians in disaster situations. ODS coordinates efforts with the State Emergency Management Agency, the Department of Health and Senior Services, other state agencies and voluntary agencies active in disaster (VOAD). ODS also develops and administers the FEMA/SAMHSA Crisis Counseling Program (CCP) grant when there is a federal declaration in Missouri. ODS coordinates the DMH Show-Me Response network that in the event of a disaster deploys volunteers of licensed professionals such as psychiatrists, psychologists, licensed clinical social workers, licensed marriage and family therapists, licensed professional counselors, certified substance use treatment counselors, developmental disability professionals, and non-licensed disaster behavioral health strike team members. ODS represents DMH on the Governor's Faith-Based & Community Service Partnership for Disaster Recovery and the Missouri VOAD to aid Missourians' recovery plans by developing and implementing a holistic approach to disaster recovery.

Administration

The Division of Behavioral Health's (DBH) administration unit includes budgetary/financial analysis and monitoring, grants management, and the Customer Information and Management Outcomes and Reporting (CIMOR) Help Desk.

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Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's behavioral health system, including for other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps. The state's priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Use Disorder Treatment Services (N-SSATS), the Behavioral Health Barometer, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the **Uniform Reporting System** (URS), and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States with current Partnership for Success discretionary grants are required to have an active SEOW.

This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the MHBG and SUPTRS BG priority populations, as well as a discussion of the unmet service needs and critical gaps in the current system for underserved communities, as defined under **EO 13985**. States are encouraged to refer to the **IOM reports**, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* and ***The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding***[1] in developing this narrative.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Assessment of Need

Behavioral Health Data

The Missouri Department of Mental Health (DMH) utilizes prevalence data, behavioral health indicators, treatment admissions data, population estimates, needs assessments, and outcomes data for planning purposes. DMH assimilates behavioral health-related data from several national and state surveys. DMH acquires state and sub-state estimates from the National Survey on Drug Use and Health (NSDUH), state estimates from the Youth Risk Behavior Survey (YRBS), state estimates from the Behavior Risk Factor Survey (BRFS), state and county-level data from the Missouri Student Survey (MSS) for grades 6th through 12th, and state data collected from 24 of Missouri's universities and colleges using the Missouri Assessment of College Health Behaviors (MACHB). DMH annually updates prevalence estimates using the most current survey data.

DMH collects an array of behavioral health indicator data, mostly from other state agencies. The indicators include traffic crashes, fatalities, injuries, and DUI arrests; HIV/AIDS cases; hospital and emergency room admissions; substance positive births; substance-induced deaths; adult and juvenile arrests; school discipline incidents; out-of-home juvenile placements; methamphetamine lab confiscations; probation, parole, and prison admissions; drug overdose deaths; suicide rates; and drug, DUI, and mental health court enrollments. DMH also collects other indicator data including school dropouts, juvenile status offenses, domestic violence, violent and property crime indices, and unemployment rates. On an annual basis, DMH assembles the indicators into geographic profiles for Missouri's 114 counties plus the city of St. Louis, service areas, planning regions, and the state.

Substance use and mental health treatment admissions data are retrieved from the DMH Customer Information, Management, Outcomes, and Reporting (CIMOR) system, based on each consumer's county of residence. Information on demographics, substances used, diagnoses, and treatment services are assembled by fiscal year into geographic profiles for the counties, planning regions, service areas, and state. These profiles are included in DMH's annual Status Report on Missouri's Substance Use and Mental Health Problems.

State Epidemiology Outcomes Workgroup

In 2010, Missouri was awarded a State Epidemiology Outcomes Workgroup (SEOW) contract, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). The state used this funding to revitalize its SEOW workgroup that had been established under the Strategic Prevention Framework State Incentive Grant (2004-2009) to address underage drinking. The mission of Missouri's current SEOW is to:

- Create and implement a systematic process for gathering, reviewing, analyzing, integrating, and monitoring data that will delineate a comprehensive and accurate picture of behavioral health issues in the State and it's communities;
- Inform and guide behavioral health prevention policy, program development and evaluation in the State; and
- Disseminate information to State and community agencies, targeted decision-makers, and the general public.

The SEOW is chaired by an epidemiologist at the Missouri Institute for Mental Health – University of Missouri (MIMH), St. Louis. The core group comprises of the four epidemiologist funded through the state (1) and community (3) Partnerships for Success grantees. Additional feedback is gathered from the Department of Mental Health and other stakeholders as appropriate.

As part of the SAMHSA-funded Partnership for Success 2020 Grant (2020-2025), the SEOW has been responsible for providing data expertise and support to Partnership sub-recipients in reducing risk factors and promoting protective factors common to alcohol, tobacco, and other drug use, including development of a methamphetamine data collection tool. As part of the broader behavioral health system, the SEOW workgroup continues to assess data gaps, enhance capacity to use behavioral health data, promote data driven decision-making, increase dissemination of data and analyses, promote common data standards, and increase data collaborations.

Overall Need

Serious Emotional Disturbance (Children) and Serious Mental Illness (Adults)

Sub-state Planning Area	2020 Population Age 0-17	Estimated Need (7%)	Received Treatment FY 2023	Estimated Served Outside of State System + Unmet Need	Percent of Need Not Served by State System
Western	494,287	34,601	8,170	26,431	76.39%
Eastern	503,950	35,277	6,788	28,489	80.76%
Southwest	218,120	15,269	5,921	9,348	61.22%
Southeast	155,072	10,856	4,383	6,473	59.63%
State Total	1,371,429	96,001	25,262	70,739	73.69%

Table 1. FY 2023 Estimated prevalence of childhood serious emotional disturbance.

Sub-state Planning Area	2020 Population Age 18+	Estimated Need (6.06%)	Received Treatment FY 2023	Estimated Served Outside of State System + Unmet Need	Percent of Need Not Served by State System
Western	1,686,960	102,230	20,989	81,241	79.47%
Eastern	1,799,117	109,027	21,630	87,397	80.16%
Southwest	753,751	45,678	10,857	34,821	76.23%
Southeast	540,291	32,742	11,619	21,123	64.51%
State Total	4,780,119	289,676	65,095	224,581	77.53%

Table 2. FY 2023 Estimated prevalence of adult serious mental illness.

State estimates for serious mental illness (SMI) (adults) and serious emotional disturbances (SED) (children) are obtained from estimates published in the federal register (FR Doc. 98-19071; FR Doc. 99-15377). Based on these historically reported estimates, approximately 5.4% of the Missouri adult population has an SMI and 7% of Missouri children and youth have a SED. Based on NSDUH data, 6.06% of Missouri adults have an SMI (SAMHSA, 2021). A study by Mark and Buck (2006) examining characteristics of U.S. youth with SED found that about 44% were covered by private insurance, 31% were enrolled in Medicaid/Children's Health Insurance Program (CHIP), 11% were covered by another unspecified public program, and about 14 were uninsured. It is reasonable to assume that the majority if not the entire uninsured group represents unmet need. It is not known what portion of the private insurance group did not have sufficient coverage for adequate care of the child's SED condition.

Substance Use Disorder

Sub-state Planning Area	2020 Population Age 12-17	Estimated Prevalence (9.46%)	FY 2023 Served	Estimated Served Outside of State System + Unmet Need	Percent of Need Not Served by State System
Western	168,710	15,960	418	15,542	97.38%
Eastern	173,513	16,415	575	15,840	96.50%
Southwest	75,382	7,132	349	6,783	95.11%
Southeast	54,469	5,153	293	4,860	94.31%
State Total	472,074	44,660	1,635	43,025	96.34%

Table 3. FY 2023 Estimated prevalence of adolescent substance use disorder.

Sub-state Planning Area	2020 Population Age 18+	Estimated Prevalence (18.28%)	FY 2023 Served	Estimated Served Outside of State System + Unmet Need	Percent of Need Not Served by State System
Western	1,686,960	308,3077	16,073	292,304	94.79%
Eastern	1,799,117	328,879	13,994	314,885	95.74%
Southwest	753,751	137,786	8,119	129,667	94.11%
Southeast	540,291	98,766	6,609	92,157	93.31%
State Total	4,780,119	873,808	44,795	829,013	94.87%

Table 4. FY 2023 Estimated prevalence of adult substance use disorder.

County-level population of individuals age 12 or older was obtained from the Missouri Department of Health and Senior Service, Population MICA database and aggregated to the sub-state areas (Department of Health and Senior Services, 2023). Statewide estimates for substance use disorder treatment need are obtained from the National Household Survey (NSDUH) (SAMHSA, 2021). The difference between estimated need and number served yields the combination of estimated served outside of the state system and unmet need.

Coordination of Primary Care and Behavioral Health Services

Individuals with serious mental illness die 11 to 32 years prematurely from preventable chronic health conditions such as heart disease, diabetes, cancer, pulmonary disease, and stroke (National Institute on Mental Health, 2012). In addition, individuals with co-occurring mental illness and substance use disorders are at greater risk for relapse and tend to have poorer outcomes in comparison to individuals with only a substance use disorder (Compton, W.M., Cottler, L.B., Behn-Abdallah, A., & Spitnagel, E.L., 2003; Hser, Y.I., Evans, E., Teruva, C., Huang, D., & Anglin, M.D., 2007; Daigre, C., Rodriguez, L. Roncero, C., Palma-Alvarez, R.F., et al., 2021). Expenditures for co-occurring individuals on Medicaid tend to be higher because of not only the substance use and mental illness disorders but also accompanying physical disorders (Clark, R.E., Samnaliev, M., & McGovern, M.P., 2009). The DMH has implemented a Behavioral Health Home model for its Community Mental Health Centers (CMHC) and Certified Community Behavioral Health Organizations (CCBHOs), as well as disease management programs for both serious mental illness and substance use disorders. Under the Behavioral Health Home model, individuals with serious mental illness served by the CMHC's and CCBHO's have monitoring of their health status; coordination of their care including their physical health needs; individualized care planning; and promotion of self-management. For an individual to be eligible for enrollment in Missouri's Behavioral Health Home, they must meet one of the following three conditions:

1) Have a serious and persistent mental illness;
2) Have a mental health condition and a substance use disorder; or
3) Have a mental health condition or a substance use disorder and one other chronic health condition.

In 2022, Missouri's Behavioral Health Home updated the qualifying conditions for enrollment to include Complex Trauma in order to expand the opportunity for Behavioral Health Home's to

serve children and youth who need integrated health services. The Behavioral Health Home staffing requirements were also updated. The Primary Care Physician Consultant was transitioned to a Specialized Healthcare Consultant which will allow Behavioral Health Homes flexibility in offering additional consultation from a variety of healthcare professionals for special populations. Staffing options includes the following healthcare professionals: Primary Care Physician, Registered Dietician or Registered Dietician Nutritionist, Occupational Therapist, and Speech Language Pathologist.

DMH's Disease Management Programs target Medicaid-enrolled adults with serious mental illness or substance use disorders and high medical costs who are not currently engaged in behavioral health treatment.

Crisis Intervention

Individuals experiencing a crisis due to a behavioral health condition often visit the emergency room or have contact with law enforcement or other first responders. In 2020, Missouri had over 52,000 emergency room visits in which the primary diagnosis was for a mental illness. Additionally, in Missouri roughly 34,000 emergency room visits in which the primary diagnosis was for alcohol and/or drug use (Smith, R. *et al*, 2022). Research suggests that about 7% of all police contacts in urban settings involve a person experiencing mental illness and up to 60-90% of police report responding to a call involving mental illness at least once per month (Hacker, R.L., & Horan, J.J., 2019). In a random sample of 500 recent admissions to Missouri's penal institutions, about one-half (48%) were assessed with serious functional impairment due to a substance use disorder and 14% were under clinical care for a mental illness (Missouri Department of Mental Health, 2015). DMH has implemented several projects: 1) Community Behavioral Health Liaisons (CBHLs), 2) Emergency Room Enhancement (ERE) Projects, 3) Crisis Intervention Team (CIT), 4) Access Crisis Intervention (ACI) hotlines, and 5) Behavioral Health Crisis Centers (BHCCs) and 6) the 988 Suicide & Crisis Lifeline with the goals of increasing access to treatment and improving individual outcomes.

Tobacco Prevention / Cessation

Past Month Cigarette Use for Selected Groups	Missouri	U.S.
Youth Age 12-17	3.95%	2.63%
Young Adults Age 18-25	25.00%	16.78%
Older Adults Age 26+	31.25%	21.96%

Table 5. Prevalence of Current Cigarette Use (SAMHSA, 2021)

Estimates of past month cigarette use were obtained from the National Household Survey on Drug Use and Health (SAMHSA, 2021). Prevalence of cigarette use for Missouri tends to be higher than that for the U.S.

Research has shown that higher merchant compliance with tobacco control laws predicts lower levels of youth smoking (DiFranza, Savageau, & Fletcher, 2009). The Missouri Department of Mental Health - Division of Behavioral Health (DBH) is the state agency that oversees the

state's federal Synar requirements and partners with the Department of Public Safety – Division of Alcohol and Tobacco Control for tobacco control efforts. Federal Synar regulations require all states to maintain a retailer non-compliance rate of no more than 20% (42 U.S.C. 300x-26 and 45 C.F.R. 96.130). Since 1996, DBH is charged with overseeing the Synar requirements in Missouri, conducting the annual Synar survey, and implementing tobacco prevention activities as it relates to the sale of tobacco products to minors. A state that fails to comply with the federal Synar requirements is at risk for losing Substance Abuse Prevention and Treatment Block Grant funding.

Recovery Support Services

Substance Use

Research has shown that, for many individuals, recovery coaching, 12-step programs, spirituality, and social and community supports play an important role in maintaining long-term recovery from substance use disorders (Eddie, D., Hoffman, L., Vilsaint, C., Abry, A., Bergman, B., *et al*., 2019). DBH funds peer support services for individuals in substance use treatment and recovery services. These services are individual or group services with a rehabilitation and recovery focus. Peer support services have shown to be highly effective in engaging individuals in services who might otherwise be reluctant to seek treatment.

Missouri DBH funds four Recovery Community Centers (RCC) through the State Opioid Response Grant. DBH awarded four additional RCC contracts with the SABG supplemental funding. RCCs are independent, non-profit organizations that help individuals recovering from substance use disorders. They help build recovery capital by providing advocacy training, recovery information, mutual-help or peer-support groups, social activities, and other community-based services. In 2022, Missouri RCCs served 25,909 individuals. More than 16,189 of those served were individuals with an Opioid Use Disorder (OUD). In 2022, 1,281 individuals utilized employment assistance services in the RCCs.

Serious Mental Illness

For the provision of behavioral healthcare to individuals with severe mental illness, research has shown that peer support staff function at least as well as non-peer staff in roles such as case managers, rehabilitation staff, and outreach workers. Moreover, peer services tend to generate better outcomes in engaging the "difficult-to-engage" consumers, reducing hospitalizations for individuals, and in decreasing substance use among co-occurring consumers (Davidson, L., Bellamy, C., Guy, K., & Miller, R., 2012). Research shows that the combination of peer-run services and community treatment services increased service recipient empowerment and reduced self-stigma among participants (Segal, S.P., Silverman, C.J., Temkin, T. L, 2013). DMH funds four drop-in centers. Consumer-operated services programs (COSP) are peer-run service programs that are administratively controlled and operated by individuals with mental health recovery and emphasize self-help as their operational approach.

Drop-In Centers are a safe place where individuals can go to find recovery programs and services provided by their peers. They offer a wide variety of services including recovery focused support groups, life enhancement skills, goal setting, problem solving, and, computer and internet access as well as socialization with others in recovery. Anyone with a mental health diagnosis or who is or has experienced symptoms of a mental illness is welcome to participate in services. All services are self-directed and free of charge. DMH also contracts for one statewide peer-run phone support line.

Certified Missouri Peer Specialist training began in 2008 in Missouri. After researching peer support training curricula, the Comprehensive Psychiatric Services State Advisory Council (CPS/SAC) made the recommendation for the Appalachian Consulting Group "Georgia Model" which was subsequently adopted by the Division of Behavioral Health. The DMH has moved the mental health system to a wellness model that empowers service participants to establish their personal mental health goals and manage both their mental health and plan of care through education and supports. One primary strategy in transforming the system is to recognize the power of peers as providers. Recognizing the critical role of peer specialists as providers is taking root in the mental health system. Emerging evidence supports the need for peer support services as a cost-effective and complementary adjunct to professional mental health services and supports. Peer support services can move the system to focus less on illness and disability and more on wellness. To accomplish this goal, Missouri has provided equal weight to expertise gained through the "lived experience" as is done with any other credential or knowledge base. A Peer Specialist can share lived experiences of recovery, share and support the use of recovery tools, and model successful recovery behaviors. Through this process, individuals can learn to identify their strengths and personal resources, learn to make independent choices, and take a proactive role in their treatment. Additionally, Peer Specialists can help individuals connect with others and with their community at large.

In March 2018, DBH integrated the Certified Missouri Peer Specialists (CMPS) certification with the Missouri Recovery Support Specialist – Peer certification to create the Certified Peer Specialist credential. The weeklong training is conducted by trained individuals with lived experience of recovery. Over 1,500 individuals are currently active Certified Peer Specialist (CPS). CPSs are employed around the state providing services in community mental health centers, recovery support services, recovery community centers, consumer operated service programs (Drop-In Centers), the Veteran's Administration, substance use disorder treatment providers, the State Opioid Response Engaging Patients in Care Coordination (EPICC), as well as five of our state operated psychiatric facilities. The Medicaid reimbursement rate is comparable to that of a Community Support Specialist and continues to be utilized among Missouri providers.

Medication Assisted Treatment for Substance Use Disorder

Sub-state Planning Area	FY 2023 Number Served who Had an Alcohol and/or Opiate Use Disorder	FY 2023 Number who Received MAT Services	% Received MAT Services
Western	10,378	3,761	36.24%
Eastern	10,439	5,585	53.50%
Southwest	5,207	1,899	36.47%
Southeast	3,908	1,826	46.72%
State Total	29,932	13,071	43.67%

Table 6. Number served in state system with an Opioid or alcohol use disorder identified as the primary, secondary, or tertiary substance use disorder and the number who received MAT services including methadone, Vivitrol, naltrexone, buprenorphine-containing medications, Antabuse, and acamprosate.

Medication assisted treatment (MAT) is the use of medications, in combination with psychosocial counseling, to support treatment and recovery from substance use disorders. DMH fully supports the use of evidence-based practices in substance use treatment, which includes MAT. DMH funds Opioid Treatment Programs (OTP) that are certified to provide methadone maintenance treatment at 15 locations in Missouri. In addition, DMH began introducing new medications into its non-Opioid treatment programs in 2006 as part of a Robert Woods Johnson Advancing Recovery Grant. Medication services were added to treatment contracts in 2007. In 2010, Missouri began credentialing for a MAT specialty. DMH continues to expect providers to use MAT when clinically indicated. Missouri's efforts in expanding the use of evidence-based practices for the treatment of OUD, including the use of substance use treatment medications, was considerably enhanced with the federal opioid crisis grants. These grants have helped increase the pace and scale of Evidence Based Practice (EBP) adoption and gave rise to Missouri's "Medication First" approach to treating OUD. The National Quality Forum indicated that that better outcomes are associated with pharmacotherapy. (National Quality Forum, 2019). Currently, the State Opioid Response grant contracts with 25 MAT providers, including Opioid Treatment Programs in order to increase access to MAT for uninsured or underinsured individuals with an OUD. The goal of SOR's treatment efforts are to increase access to medication for OUD through provider training, direct service delivery, and telemedicine formats. In FY 20, the treatment of stimulant use disorder with SOR funding became allowable. Six SOR treatment providers with higher rates of individuals presenting with a stimulant use disorder were awarded contracts that provided needed funding for stimulant use disorder treatment with the incorporation of contingency management.

Community Advocacy and Education

Substance Use

Approximately 873,000 Missourians have a substance use disorder (SAMHSA, 2021). Substance use is impacted by social acceptability including community laws and norms favorable toward use as well as by availability of the substances. Missouri's approximately 165 community coalitions; the 10 Prevention Resource Centers; and Missouri's higher education substance use consortium, Partners in Prevention (PIP) work to change community norms, policy, and substance availability in support of creating healthy, safe communities. The Prevention Resource Centers, in collaboration with the community coalitions, develop, implement, and evaluate a comprehensive strategic plan with identified target outcomes based on community needs.

	Missouri	U.S.
Nonmedical Use of Pain Relievers in Past Year, Age 12+	1.78%	1.79%
Alcohol Use in Past Month, Age 12-17	7.24%	6.99%
Tobacco Use in Past Month, Age 12+	27.93%	19.55%

Table 7. Estimates of Substance Use (SAMHSA, 2021)

Some issues facing Missouri's communities include: 1) methamphetamine imported from out of state; 2) prescription drug misuse; 3) underage drinking, and 4) continued availability and use of heroin in Eastern Missouri. In addition, the statewide use of tobacco products tends to be higher than that for the country as a whole. Approximately 1.78% of Missourians age 12 or older engaged in prescription pain reliever misuse in the past year (SAMHSA, 2021). In 2021, the estimated current use of tobacco by Missourians age 12 or older was 27.93% – higher than that for the United States (19.55%) (SAMHSA, 2021).

Mental Illness

	Age 12-17		Age 18+	
	Missouri	U.S.	Missouri	U.S.
Serious Mental Illness in the Past Year			6.06%	5.55%
Had Serious Thoughts of Suicide in Past Year			5.05	4.58%
Had at Least One Major Depressive Episode in the Past Year	22.41%	20.10%	9.36%	8.29%

Table 8. Prevalence of Mental Illness (SAMHSA, 2021).

Behavioral health issues such as substance use disorders and mental illness often carry a stigma that prevents individuals from seeking help and others from providing help. Of those Research has shown that Mental Health First Aid (MHFA), a public education program designed for the general public in appropriately responding to behavioral health issues, is associated with

increased knowledge of behavioral health disorders, less stigmatization, and greater confidence to provide assistance (Kitchener, J.A., 2004; Kitchener, B.A. & Jorm, A.F., 2004). The Missouri Department of Mental Health partners with the National Council for Mental Wellbeing to implement Mental Health First Aid. Missouri also offers Mental Health First Aid for Youth, for adults who work with young people and tMHFA which teaches teens in grades 10th - 12th , or ages 15-18 how to identify, understand and respond to signs of mental health and substance use challenges in their friends and peers.

School-Based Behavioral Health Education

	Missouri	United States
Past Month Illicit Drug Use	7.12%	7.09%
Past Month Binge Alcohol Use	3.25%	3.82%
Past Month Cigarette Use	2.23%	1.51%
Past Year Major Depressive Episode	22.47%	20.10%

Table 9. Behavioral Health Measures: Age 12 - 17 (SAMHSA, 2021).

An estimated 14.9% of Missouri's youth in grades 6th through 12th report using alcohol in the past 30 days. In addition, 7.5% and 11% reported using marijuana and electronic cigarettes, respectively, in the past month (Depue, S. & et al., 2022). Missouri's School-based Prevention Intervention and Resources Initiative (SPIRIT) implements evidence-based programming to delay the onset of substance use and decrease the use of substances, improve overall school performance, and reduce incidents of violence. Age- and grade-appropriate curricula are taught. Screening and referral services are provided as needed. The program receives an annual evaluation by the Missouri Institute for Mental Health, University of Missouri-St. Louis.

Prescription Drug Overdose

Sub-state Planning Area	2020 Population	Opioid Deaths (2014-2018) Rates per 100,000 persons
Western	2,174,468	36.01
Eastern	2,299,721	126.06
Southwest	965,332	43.09
Southeast	697,907	36.82
State Total	6,137,428	70.96

Table 10. Rates of opioid deaths per 100,000 persons (DHSS, 2021).

In 2018, approximately one of every 56 deaths in Missouri is due to an opioid overdose and in St. Louis City the death rate due to opioid overdose was 100.50 per 100,000 residents. (DHSS, 2023). In 2022, there were 1,579 Missourians who lost their lives due to an opioid overdose with a rate of 25.56 (per 100,000). An estimated 1.78% or 93,400 Missourians report nonmedical use of pain relievers in the past year. The percentage is comparable to that of the country as a whole (SAMHSA, 2021). In 2020, Missouri ranked 11th when comparing the rates of prescribing opioid pain relievers among states. Missouri had 54.5 opioid pain reliever prescriptions per 100 persons – compared to the rate of 43.3 for the United States (CDC, 2020).

In June 2021, Missouri's Governor signed into law a bill which creates a statewide prescription drug monitoring program in the state of Missouri. In 2023, Missouri's paraphilia law was amended stating that it shall not be unlawful to manufacture, possess, sell, deliver, or use any device, equipment, or other material for the purpose of analyzing controlled substances to detect the presence of fentanyl or any synthetic controlled substance fentanyl analogue. Additionally, Missouri has received the opioid response grants through SAMHSA and strives to reduce the rate of opioid deaths.

Evidence-based Behavioral Health Practices

The DMH supports implementation of programs and practices that have proven effectiveness in reducing the impact of behavioral health disorders on individuals and families in Missouri. Missouri has implemented the following evidence-based practices in the treatment of serious mental illness (SMI):

- Integrated Treatment for Co-occurring mental illness and substance use disorders;
- Supported employment;
- Illness Management and Recovery;
- Assertive Community Treatment; and
- Consumer-operated services.

Individuals with co-occurring SMI and substance use disorders tend to have poorer outcomes when served in traditional treatment programs where each disorder is treated by a separate team of providers (McGovern, M.P., 2006). The evidence-based treatment model of care for individuals with co-occurring disorders that is recommended by SAMHSA is the Integrated Treatment for Co-Occurring Disorders (ITCD). In the ITCD model, persons receive coordinated, integrated treatment by a single multidisciplinary team including trained specialists in co-occurring disorders. Missouri has 27 ITCD programs operating in 48 locations. Missouri has Medicaid approved billing codes for co-occurring individual counseling, group education, group counseling, and a supplemental individual assessment for substance use disorders. DMH monitors fidelity to the SAMHSA tool kit.

Supported employment programs have been shown to be more effective than traditional vocational programs in gaining competitive employment, earning more income, and working more days for individuals with SMI (Bond, G.R. *et al*., 2008; Crowther, R.E. *et al*., 2001). Missouri has 32 supported employment programs. Providers contract with the Missouri Vocational Rehabilitation (VR) to offer supported employment services to ensure that:

- Eligibility is based on consumer choice;
- Supported employment is integrated with treatment;
- Competitive employment is the goal;
- Job search starts soon after the individual expresses interest in working;
- Follow-along supports are continuous; and

- Individual preferences are recognized.

Fidelity is monitored for the Individualized Placement Support (IPS) Supported Employment model. Missouri's successful outcome of job retention at 90 days is 52% (higher than the national average).

Illness management recovery strategies have been shown to increase the individual's knowledge of their condition, aid in medication compliance, and reduce the occurrence and severity of symptom relapse (Mueser, K.T. *et al*., 2002). DMH, in collaboration with the State Medicaid authority, has established an enhanced rate for Psychosocial Rehabilitation. Twenty community mental health centers provide these services that focus on health, wellness, and recovery. Fidelity to this evidence-based practice is not monitored.

Assertive Community Treatment (ACT) has been shown to reduce hospitalizations for individuals with severe mental illness (Phillips, S.D. *et al*., 2001). In Missouri, ACT services are made available to adults with serious and persistent mental illness who: 1) are high users of inpatient beds, 2) may have a co-occurring substance use disorder, 3) have involvement with the criminal justice system, and 4) are homeless. DMH funds nine adult ACT programs and 10 ACT Transitional Aged Youth (TAY) programs. Missouri continues to monitor fidelity of new program implementation as well as on-going services.

Research has shown that peer support staff function at least as well as non-peer staff in roles such as case managers, rehabilitation staff, and outreach workers. Moreover, peer services tend to generate better outcomes in engaging the "difficult-to-engage" consumers, reducing hospitalizations for consumers, and in decreasing substance use among co-occurring consumers (Davidson, L., Bellamy, C., Guy, K., & Miller, R., 2012). Findings from the SAMHSA Consumer-Operated Service Program (COSP) Multisite Research Initiative showed that adding peer support services or programs to traditional mental health programs was positively associated with increased personal empowerment among individuals using those services (Rogers *et al*., 2007). DMH funds four COSP Drop-In Centers and one statewide Peer Phone Support line.

In addition to the evidence-based practices listed above, DMH also funds Dialectical Behavior Therapy (DBT), a cognitive-behavioral treatment initially developed to treat individuals with borderline personality disorder (BPD) but also found to be effective for indiviudals with other diagnoses. Several studies have shown that DBT had better outcomes in the treatment of BPD compared to treatment as usual on measures of anger, parasuicidality, and mental health (Stoffers, J.M. *et al*., 2012). Introductory and advanced DBT training has been made available statewide with an aim to broaden accessibility to the treatment for adults, children and youth, and families. To ensure that the treatment delivered meets high standards of adherence to the treatment manual, DMH developed a fidelity measure modeled after that used by the Linehan Board of Certification and has undertaken the periodic review of all publicly funded teams in the state. All teams are asked to register their teams with DMH, and individual team members have the

opportunity to received "Verification" of the services they deliver by completing documentation at www.dbtmo.org. DMH has partnered with the University of Missouri Psychiatric Center to produce an online training in communication strategies. DMH also supports a DBT website (www.dbtmo.org) to provide information on DBT, and training opportunities, and to maintain a record of all registered teams, and the training and verification of individual providers within those teams.

Substance Use-Related Services for Persons who Inject Drugs

Sub-state Planning Area	2020 Population Age 20+	Estimated PWID Need	PWID FY 2023 Served	Estimated PWID Need but Not Receive	Penetration Gap
Western	1,628,200	7,815	3,797	4,018	51.42%
Eastern	1,745,820	10,824	3,670	7,154	66.09%
Southwest	728,846	3,498	2,488	1,010	28.88%
Southeast	523,540	2,513	1,788	725	28.85%
State Total	4,626,406	24,520	11,743	12,777	52.11%

Table 11. Estimates of prevalence and need for the treatment of injection drug use.

In the past, the number of individuals who inject drugs (PWID) was estimated at 0.19 percent of the population aged 12 or older from NSDUH national-level data. Based on 1) the number of PWID served and the number on wait lists and given that 2) NSDUH excludes some populations with higher rates of drug use such as incarcerated individuals, individuals who are homeless, hospitalized patients, and college dormitory students, the NSDUH estimate was believed to generate estimates for Missouri that seriously underestimates the number of indiviudals who inject drugs in the state. Research from Brady *et al*. estimated the prevalence of PWID in the U.S. and in 76 metropolitan statistical areas (MSA) (Brady, J.E. *et al*., 2008). Brady's estimates for individuals who inject drugs in the Kansas City and St. Louis MSA's exceeded that generated from the NSDUH data by a factor of 2.7 and 3.4, respectively. Brady's prevalence rate for Kansas City MSA and St. Louis MSA was applied to the populations of Western and Eastern regions. The remaining regions were assumed to have a similar rate as that of Northwest region and a corresponding estimate was generated for the remaining regions. The number of PWID's served by sub-state region was obtained from the publicly-funded system (Missouri Department of Mental Health, 2023). The estimated number for unmet need is the difference between number in need and number served. Penetration gap is that proportion of estimated need that did not receive treatment. In Missouri, methamphetamine injection drug use is prevalent throughout the rural areas of the state but is particularly notable in Southwest, Southeast, and Western Regions. Heroin and other Opioid injection drug use are highly concentrated in Eastern Region impacting both urban and rural locations. The Eastern Region accounted for 67% of the state's heroin-related deaths between 2014 and 2018 (Missouri Department of Health and Senior Services, 2021).

Substance Use-Related Services for Pregnant Women and Women with Dependent Children

An estimated 8.5% of pregnant women have a substance use disorder. In general, an estimated 5.5% of women have a substance use disorder (SAMHSA, 2020).

Sub-state Planning Area	2020 Female Population Age 12+	Women Need (5.5%)	Women FY 2023 Served	Estimated Served Outside of State System + Unmet Need	Percent of Need Not Served by State System
Western	945,743	52,016	6,441	45,575	87.62%
Eastern	1,024,952	56,372	5,176	51,196	90.82%
Southwest	424,731	23,360	3,171	20,189	86.43%
Southeast	299,767	16,487	2,621	13,866	84.10%
State Total	2,695,193	148,236	17,409	130,827	88.26%

Table 12. Prevalence of substance use problems among women (SAMHSA, 2020).

County-level population of females age 12 or older was obtained from the Missouri Department of Health and Senior Services, Population MICA and aggregated to the sub-state areas (Department of Health and Senior Services, 2023). The estimated percent in need of treatment (5.5%) is obtained from the SAMHSA Behavioral Health Barometer report (SAMHSA, 2020). The number served in the state system in FY 2023 was obtained from the Department of Mental Health information system. The difference between estimated need and number served is a combination of number served outside of the state system and unmet need.

Mental Health Services for Transition-Aged Youth and Young Adults

Sub-state Planning Area	2020 Population 16-17	2020 Population 18-25	Estimated Need, Age 16-17 (7%)	Estimated Need, Age 18-25 (12.18%)	Total Estimated Need
Western	55,525	242,275	3,887	29,509	33,396
Eastern	57,970	221,951	4,058	27,034	31,092
Southwest	24,830	106,241	1,738	12,940	14,678
Southeast	18,009	68,189	1,261	8,305	9,566
State Total	156,334	638,656	10,943	77,788	88,732

Table 13. Estimated need for mental health services among transition age youth and young adults.

Individuals who are transitioning into adulthood and have or develop a serious mental illness face unique challenges. Compared to the general population, these individuals tend to have increased difficulty in reaching developmental milestones such as graduating from high school, gaining employment, securing stable housing, and developing and sustaining meaningful relationships. In a study by the U.S. Government Accounting Office (GAO) (2008), young adults

age 18 to 26 with SMI graduated from high school at a lower rate compared to those without SMI (64% vs. 83%). For young adults who were receiving disability payments from SSI or DI, the high school graduation rate was even lower at 52%. Transition-age youth are more likely to become involved with the juvenile justice system and are at increased risk for substance use (Gilmer, T. P. *et al*., 2012). Although SMI may develop earlier than age 16, it is not uncommon for the diagnosis to be made during the late teens and early twenties. As such, individuals and their families may be inexperienced at navigating multiple systems of care and programs. Adult and youth programs often have differing eligibility requirements and service mix that can cause disruptions in continuity of care once an individual reaches age 18. In looking at mental health service utilization in the U.S., Pottick *et al*. (2008) found that service utilization fell by almost 50% at the age of emancipation. Adult programs may be more tailored to the needs of older adults which may cause young adults to feel disenfranchised and result in treatment drop-out (GAO, 2008).

Behavioral Healthcare Services for Children

Sub-state Planning Area	2020 Population Age 0-17	Estimated Need (7%)	Received Treatment FY 2023	Estimated Served Outside of State System + Unmet Need	Percent of Need Not Served by State System
Western	494,287	34,601	8,170	26,431	76.39%
Eastern	503,950	35,277	6,788	28,489	80.76%
Southwest	218,120	15,269	5,921	9,348	61.22%
Southeast	155,072	10,856	4,383	6,473	59.63%
State Total	1,371,429	96,001	25,262	70,739	73.69%

Table 14. FY 2023 Estimated prevalence of childhood serious emotional disturbance.

Sub-state Planning Area	2020 Population Age 12-17	Estimated Need (9.46%)	Received Treatment FY 2023	Estimated Served Outside of State System + Unmet Need	Percent of Need Not Served by State System
Western	168,710	15,960	418	15,542	97.38%
Eastern	173,513	16,415	575	15,840	96.50%
Southwest	75,382	7,132	349	6,783	95.11%
Southeast	54,469	5,153	293	4,860	94.31%
State Total	472,074	44,660	1,635	43,025	96.34%

Table 15. FY 2023 Estimated prevalence of adolescent substance use disorder.

Children and youth with behavioral health issues face challenges in many aspects of their daily lives. Missouri supports the systems of care approach that recognizes the importance of

family, school, and community and in which services are provided through a comprehensive, seamless system. Both substance use disorder and mental health services for children and youth are coordinated under the Department of Mental Health (DMH) Children's Director and Division of Behavioral Health program staff. Community Psychiatric Rehabilitation (CPR) provides a range of essential mental health services to children and youth with serious emotional disturbances. The Comprehensive Substance Treatment and Rehabilitation (CSTAR) Adolescent program offers a full continuum of services for youth age 9 to 17 with substance use disorders.

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Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Coordination of Primary Care and Behavioral Health Services

Priority Type: SUT, MHS

Population(s): SMI, PWWDC, PWID

Goal of the priority area:

Coordinate individuals primary and behavioral healthcare in order to improve health and reduce medical costs.

Strategies to attain the goal:

1) Continue to coordinate preventative and primary care for Health Home participants.
2) Continue outreach to Medicaid-enrolled adults who have substance use disorders and/or serious mental illness, have high annual healthcare costs, and are not currently enrolled in behavioral health treatment
3) Contract with the Missouri Institute for Mental Health (MIMH) for ongoing evaluation of Missouri's Health Home programs.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of participants in Health Homes per fiscal year

Baseline Measurement: 31,976

First-year target/outcome measurement: 31,500

Second-year target/outcome measurement: 31,500

Data Source:

Missouri Medicaid data

Description of Data:

The number of Health Home participants are reported to DMH through accounting of attestation of services and/or "per member per month" payments to the Health Home contracted providers.

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Number of participants in DM 3700 per fiscal year

Baseline Measurement: 6,911

First-year target/outcome measurement: 5,700

Second-year target/outcome measurement: 5,700

Data Source:

DMH information system

Description of Data:

A participant in DM 3700 is defined as a consumer who is listed on the master list of DM 3700 participants and has an open episode of care for behavioral health services, including mental health or substance use, during the specified fiscal year.

Data issues/caveats that affect outcome measures:

None

Indicator #: 3

Indicator: Number of participants in SUD Disease Management per fiscal year

Baseline Measurement: 2,345

First-year target/outcome measurement: 1,800

Second-year target/outcome measurement: 1,800

Data Source:

DMH Information System

Description of Data:

A participant in SUD Disease Management (SUD DM) is defined as a consumer who is listed on the master list of SUD DM participants, and has an open episode of care for behavioral health services, including mental health or substance use, during the specified fiscal year.

Data issues/caveats that affect outcome measures:

None

Priority #: 2

Priority Area: Crisis Intervention

Priority Type: MHS, BHCS

Population(s): SMI, SED, BHCS

Goal of the priority area:

Promote safety and emotional stability of individuals in their communities, minimize further deterioration of mental state, increase access to treatment and support services and improve outcomes for individuals in behavioral health crisis; better utilize limited criminal justice and healthcare resources by utilizing less invasive interventions and linking individuals in need of behavioral healthcare services with those services and resources.

Strategies to attain the goal:

1) Identify and address structural barriers, miscommunications, and consistent patterns that reduce access to behavioral healthcare services.
2) Provide behavioral health expertise to law enforcement, court personnel, and primary healthcare staff in order to more effectively respond to behavioral health crises.
3) Advocate for and engage individuals in crisis in behavioral health treatment and support services.
4) Provide immediate person-centered/trauma-informed interventions to individuals in behavioral health crisis and facilitate timely access to services and supports.
5) Promote crisis services, such as 988, to individuals across Missouri. Enhance knowledge of available crisis services and resources.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of referrals to CBHLs per fiscal year

Baseline Measurement: 10,472

First-year target/outcome measurement: 15,000

Second-year target/outcome measurement: 20,000

Data Source:

Missouri Behavioral Health Council (MBHC)

Description of Data:

Number of Community Behavioral Health Liaison contacts are tracked by the MBHC

Data issues/caveats that affect outcome measures:

An individual may account for more than one contact during the fiscal year.

Indicator #: 2

Indicator: Number served in ERE project per fiscal year

Baseline Measurement: 2,029

First-year target/outcome measurement: 1,900

Second-year target/outcome measurement: 2,250

Data Source:

Missouri Behavioral Health Council (MBHC)

Description of Data:

Number of persons served in the Emergency Room Enhancement (ERE) project is tracked and reported by the MBHC.

Data issues/caveats that affect outcome measures:

None

Indicator #: 3

Indicator: Number of law enforcement officers trained in CIT per fiscal year

Baseline Measurement: 1,217

First-year target/outcome measurement: 900

Second-year target/outcome measurement: 900

Data Source:

Missouri Behavioral Health Council (MBHC)

Description of Data:

Number of officers trained in CIT is tracked and reported by the MBHC

Data issues/caveats that affect outcome measures:

None

Indicator #: 4

Indicator: Number of calls, texts, and chats to 988 per fiscal year

Baseline Measurement: 59,732

First-year target/outcome measurement: 65,000

Second-year target/outcome measurement: 70,000

Data Source:

DBH Prevention and Crisis Unit via Vibrant Emotional Health monthly reports

Description of Data:

Number of calls, texts and chats answered in Missouri

Data issues/caveats that affect outcome measures:

None

Indicator #: 5

Indicator: Number of Behavioral Health Crisis Centers

Baseline Measurement: 18

First-year target/outcome measurement: 22

Second-year target/outcome measurement: 24

Data Source:

Missouri Behavioral Health Council (MBHC)

Description of Data:

BHCCs report data to the Missouri Behavioral Health Council

Data issues/caveats that affect outcome measures:

None.

Priority #: 3

Priority Area: Department of Corrections Community Supervised Offenders

Priority Type: SUT, MHS

Population(s): SMI, Other

Goal of the priority area:

Improve access to clinically appropriate services for offenders on community supervision.

Strategies to attain the goal:

1) Monitor and target technical assistance to Probation and Parole Officers and treatment providers on the prioritization process for offenders in need of substance use disorder (SUD) treatment in order to facilitate rapid assessment and treatment initiation.
2) Maintain Memorandum of Understandings (MOU) with the Department of Corrections for coordination of behavioral health treatment services.
3) Continue the Community Mental Health Treatment (CMHT) and Offenders with Serious Mental Illness (OSMI) programs.
4) Continue to participate on the DOC Oversight Committee.
5) Coordinate with Department of Corrections (DOC) to administrate the Improving Community Treatment Success (ICTS) program with a focus on reducing the risk of harm due to substance use and mental health conditions, reducing recidivism, improving opportunities for employment or education, and improving the availability of stable housing.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Current MOUs between DMH and DOC

Baseline Measurement: Yes

First-year target/outcome measurement: Yes

Second-year target/outcome measurement: Yes

Data Source:

DMH Contracts Unit

Description of Data:

MOUs are maintained by the DMH Contracts Unit.

Data issues/caveats that affect outcome measures:

None.

Indicator #: 2

Indicator: Number of Oversight Committee Meetings

Baseline Measurement: 13

First-year target/outcome measurement: 6

Second-year target/outcome measurement: 6

Data Source:

The Division of Behavioral Health (DBH) Director of Integrated Care is the organizer of these meetings

Description of Data:

Oversight meetings are scheduled by the DBH Director of Integrated Care.

Data issues/caveats that affect outcome measures:

None.

Indicator #: 3

Indicator: Number of individuals served in ICTS programs

Baseline Measurement: 548

First-year target/outcome measurement: 700

Second-year target/outcome measurement: 700

Data Source:

DMH Information System

Description of Data:

The number of individuals served in the ICTS program is tracked in the DMH Information System

Data issues/caveats that affect outcome measures:

None

Priority #: 4

Priority Area: Tobacco Prevention

Priority Type: SUP

Population(s): PP, Other

Goal of the priority area:

Reduce tobacco initiation and promote tobacco cessation among vulnerable populations

Strategies to attain the goal:

1) Support provider training in tobacco cessation with proven effectiveness.
2) Promote the inclusion of tobacco cessation in the consumer's behavioral treatment plan.
3) Support tobacco cessation in Missouri's college campuses.
4) Ensure the provision of tobacco enforcement and merchant education:
a) Continue contracting with the Food and Drug Administration for the enforcement of federal tobacco control laws.
b) Maintain a Memorandum of Understanding with the Division of Alcohol and Tobacco Control for state and federal enforcement of tobacco control laws.
c) Conduct a merchant education visit to every tobacco retailer in the state.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Annual Synar non-Compliance rate is less than 20 percent

Baseline Measurement: Yes

First-year target/outcome measurement: Yes

Second-year target/outcome measurement: Yes

Data Source:

Annual Synar Report

Description of Data:

Synar non-compliance rate is determined from the Annual Synar Survey. For FY2024, the Annual Synar Survey will be completed by October 1, 2024. For the FY 2025, the Annual Synar Survey will be completed by October 1, 2025.

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Number of tobacco retailers visited and provided with retailer education materials per fiscal year

Baseline Measurement: 5,456

First-year target/outcome measurement: 4,800

Second-year target/outcome measurement: 4,800

Data Source:

Annual Synar Report

Description of Data:

Number of tobacco retailers visited and provided education materials is reported in the Annual Synar Report.

Data issues/caveats that affect outcome measures:

None.

Indicator #: 3

Indicator: Number of Tobacco Treatment Specialists

Baseline Measurement: 25

First-year target/outcome measurement: 50

Second-year target/outcome measurement: 50

Data Source:

DBH Integrated Programs Unit

Description of Data:

Number of Tobacco Treatment Specialists is tracked by the Director of Integrated Care.

Data issues/caveats that affect outcome measures:

None.

Priority #: 5

Priority Area: Recovery Support Services

Priority Type: SUR, MHS

Population(s): SMI, SED, Other

Goal of the priority area:

Provide support services to promote sustained recovery from behavioral health disorders.

Strategies to attain the goal:

1) Continue to grow the number of Certified Peer Specialists working in Missouri's behavioral health treatment and recovery system of care.
2) Continue the four Drop-In Centers for persons with mental illness.
3) Promote the use of IPS Supported Employment.
4) Promote the use of Family Support and Youth Peer Support.
5) Promote the use of Recovery Support Services.
6) Maintain a housing unit to administer the Continuum of Care (CoC) grants to provide housing assistance to the chronically homeless.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of Certified Peer Specialists

Baseline Measurement: 1,003

First-year target/outcome measurement: 850

Second-year target/outcome measurement: 1,000

Data Source:

Division of Behavioral Health (DBH) Recovery Services Unit

Description of Data:

The number of Certified Peer Specialists is tracked by the DBH Recovery Services Unit.

Data issues/caveats that affect outcome measures:

None.

Indicator #: 2

Indicator: Number of contracts for Consumer Operated Services Programs for persons with mental illness per fiscal year

Baseline Measurement: 4

First-year target/outcome measurement: 4

Second-year target/outcome measurement: 4

Data Source:

DMH Contracts Unit

Description of Data:

Contracts are maintained by the DMH Contracts Unit

Data issues/caveats that affect outcome measures:

None.

Indicator #: 3

Indicator: Number of IPS Supported Employment programs per fiscal year

Baseline Measurement: 26

First-year target/outcome measurement: 26

Second-year target/outcome measurement: 26

Data Source:

DBH Recovery Services Unit

Description of Data:

The number of IPS Supported Employment programs is tracked by DBH Recovery Services Unit staff.

Data issues/caveats that affect outcome measures:

None.

Indicator #: 4

Indicator: Number of Youth Peer Support Specialists

Baseline Measurement: 12

First-year target/outcome measurement: 15

Second-year target/outcome measurement: 15

Data Source:

DBH Recovery Services Unit

Description of Data:

The number of Youth Peer Support Specialists are tracked by the DBH Recovery Services Unit staff.

Data issues/caveats that affect outcome measures:

None.

Indicator #: 5

Indicator: Number of Recovery Support Providers

Baseline Measurement: 53

First-year target/outcome measurement: 50

Second-year target/outcome measurement: 50

Data Source:

DMH Contracts Unit

Description of Data:

Contracts are maintained by the DMH Contracts Unit.

Data issues/caveats that affect outcome measures:

None.

Priority #: 6

Priority Area: Medications for Substance Use Disorders

Priority Type: SUT

Population(s): PWWDC, PWID, Other

Goal of the priority area:

To further integrate medication therapy into the substance use disorder treatment service delivery system.

Strategies to attain the goal:

1) Monitor utilization of Medication Assisted Treatment (MAT) by provider and provide technical assistance as needed.
2) Increase utilization of different medications used in MAT at a given treatment provider.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of individuals receiving medication therapy per fiscal year

Baseline Measurement: 7,541

First-year target/outcome measurement: 6,500

Second-year target/outcome measurement: 6,500

Data Source:

DMH Information System and Medicaid Claims

Description of Data:

Number of consumers receiving medication assisted treatment including use of methadone, Vivitrol, naltrexone, buprenorphine-containing medications, Antabuse and acamprosate (and any future FDA-approved MAT medications) is determined from billing outside of Detoxification services.

Data issues/caveats that affect outcome measures:

The count of consumers receiving medications is likely under-reported because contracted providers may have alternative funding sources such as non-governmental grants or funds, medication samples or other means of offsetting medication costs that are not visible to the DMH data systems.

Priority #: 7

Priority Area: Community Advocacy and Education

Priority Type: SUP

Population(s): PP, Other

Goal of the priority area:

Create positive community norms, policy change, promote mental wellness, and reduce alcohol, tobacco and other drug availability in Missouri's communities.

Strategies to attain the goal:

1) Build state and community capacity for fostering strong partnerships and identifying new opportunities for collaboration.
2) Further data capacity in support of data-driven strategic planning to include the continuation of the Missouri Student Survey and the Behavioral Health web too.
3) Fund evidence-based programming to prevent substance use and bullying among high-risk youth.
4) Continue the education initiative in Eastern Missouri to address heroin and other opioid drug use.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of individuals trained in suicide prevention and intervention per fiscal year

Baseline Measurement:

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

DMH Prevention Unit

Description of Data:

The number of individuals trained in suicide prevention and intervention is tracked by contracted providers and reported to the DMH Prevention Unit.

Data issues/caveats that affect outcome measures:

None.

Indicator #: 2

Indicator: Number of high-risk youth served in prevention programs per fiscal year

Baseline Measurement: 2,960

First-year target/outcome measurement: 3,000

Second-year target/outcome measurement: 3,000

Data Source:

DBH contracted providers

Description of Data:

Number of high-risk youth served in prevention programs is tracked and reported by contracted providers.

Data issues/caveats that affect outcome measures:

None.

Indicator #: 3

Indicator: Number of persons trained in Mental Health First Aid per fiscal year

Baseline Measurement: 6,600

First-year target/outcome measurement: 6,500

Second-year target/outcome measurement: 6,500

Data Source:

DBH Prevention Uni

Description of Data:

Number trained in Mental Health First Aid (MHFA) is tracked by DBH Prevention Unit staff.

Data issues/caveats that affect outcome measures:

None.

Priority #: 8

Priority Area: School-based Prevention Education

Priority Type: SUP

Population(s): PP, Other

Goal of the priority area:

To delay onset of substance use, reduce use, improve overall school performance, and reduce incidents of violence.

Strategies to attain the goal:

1) Enhance protective factors and reverse or reduce risk factors for substance use and violence.
2) Improve academic and social-emotional learning to address risk factors.

3) Employ interactive techniques that allow for active involvement in learning.
4) Reinforce prevention skills over time with repeated interventions.
5) Ensure programming is culturally competent and age appropriate.
6) Conduct annual fidelity reviews.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of students participating in SPIRIT per fiscal year

Baseline Measurement: 9,834

First-year target/outcome measurement: 8,000

Second-year target/outcome measurement: 8,000

Data Source:

Missouri Institute for Mental Health (MIMH)

Description of Data:

SPIRIT participation is tracked and reported by the program evaluator, MIMH.

Data issues/caveats that affect outcome measures:

None.

Indicator #: 2

Indicator: Annual SPIRIT report generated

Baseline Measurement: Yes

First-year target/outcome measurement: Yes

Second-year target/outcome measurement: Yes

Data Source:

Missouri Institute for Mental Health (MIMH)

Description of Data:

Annual report is generated and provided to DMH by MIMH. DMH posts the annual report to the DMH public website.

Data issues/caveats that affect outcome measures:

None.

Priority #: 9

Priority Area: Prescription Drug Overdose Deaths

Priority Type: SUP

Population(s): PWWDC, PWID, Other

Goal of the priority area:

Prevent Opioid-related deaths and connect individuals experiencing overdose events to substance use disorder treatment

Strategies to attain the goal:

1) Increase the number of first responders, medical professionals, and other eligible groups trained to carry and administer naloxone.
2) Increase public awareness of opioid risks and best practices for assisting during an overdose event.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of individuals trained to carry and administer naloxone or another opioid antagonist per fiscal year

Baseline Measurement: 6,228

First-year target/outcome measurement: 4,000

Second-year target/outcome measurement: 6,000

Data Source:

Missouri Institute for Mental Health (MIMH)

Description of Data:

The number of individuals trained to carry and administer naloxone is tracked and reported by MIMH

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Number of naloxone kits distributed per fiscal year

Baseline Measurement: 30,642

First-year target/outcome measurement: 250,000

Second-year target/outcome measurement: 300,000

Data Source:

Missouri Institute for Mental Health (MIMH)

Description of Data:

The number of naloxone kits distributed is tracked and reported by MIMH.

Data issues/caveats that affect outcome measures:

None

Priority #: 10

Priority Area: Evidence-based Behavioral Health Practices

Priority Type: SUT, MHS

Population(s): SMI, SED, PWWDC

Goal of the priority area:

Continue evidence-based practice to the same standards and fidelity as shown to be effective in research

Strategies to attain the goal:

1) Continue to support EBP programs.
2) Provide ongoing monitoring of Fidelity in EBP programs.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of adults served in ITCD

Baseline Measurement: 3,604

First-year target/outcome measurement: 3,000

Second-year target/outcome measurement: 3,000

Data Source:

DMH Information System

Description of Data:

The number of ITCD consumers is determined from paid services in the DMH Information Systems.

Data issues/caveats that affect outcome measures:

None.

Indicator #: 2

Indicator: Number of adults served in ACT per fiscal year

Baseline Measurement: 829

First-year target/outcome measurement: 900

Second-year target/outcome measurement: 900

Data Source:

DMH Information Systems

Description of Data:

The number of adults served in the Assertive Community Treatment (ACT) program is tracked in the DMH Information Systems

Data issues/caveats that affect outcome measures:

None

Indicator #: 3

Indicator: Number of women served by Women & Children Specialty teams

Baseline Measurement: 120

First-year target/outcome measurement: 50

Second-year target/outcome measurement: 50

Data Source:

DMH contracted providers

Description of Data:

The number of women serviced by Women & Children specialty teams is tracked and reported by contracted providers.

Data issues/caveats that affect outcome measures:

None

Priority #: 11

Priority Area: Persons Who Inject Drugs

Priority Type: SUT

Population(s): PWID

Goal of the priority area:

Ensure the provision of services to persons who inject drugs in accordance with SABG statutory requirements.

Strategies to attain the goal:

1) Monitor contractual requirements pertaining to PWID
2) Generate reports to monitor length of time to initiate treatment and percent engagement in treatment
3) Increase one-on-one discussions with key provider staff about data reports and target technical assistance as needed

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of individuals who inject drugs served in substance use disorder treatment per fiscal year

Baseline Measurement: 12,830

First-year target/outcome measurement: 10,000

Second-year target/outcome measurement: 10,000

Data Source:

DMH information system

Description of Data:

The number of persons who inject drugs is determined from the route of administration for any of the substances reported in the TEDS data and paid services for substance use disorder treatment captured in the DMH information system during the fiscal year.

Data issues/caveats that affect outcome measures:

None.

Indicator #: 2

Indicator: Average number of days from initial contact to the first service paid for PWID per fiscal year

Baseline Measurement: 4.91

First-year target/outcome measurement: 6.0

Second-year target/outcome measurement: 6.0

Data Source:

DMH information system

Description of Data:

The average number of calendar days between the initial contact date to the date of service of the first paid service for PWID as reported at the treatment admission per fiscal year.

Data issues/caveats that affect outcome measures:

None

Indicator #: 3

Indicator: Percent of PWID who have engaged in treatment per fiscal year

Baseline Measurement: 85%

First-year target/outcome measurement: 80%

Second-year target/outcome measurement: 80%

Data Source:

DMH Information Systems

Description of Data:

The percent of the persons who inject drugs as reported at the treatment admission that had at least 3 paid service dates during the program.

Data issues/caveats that affect outcome measures:

None

Priority #: 12

Priority Area: Pregnant Women and Women with Dependent Children

Priority Type: SUT

Population(s): PWWDC

Goal of the priority area:

Continue to provide services to pregnant women and women with dependent children

Strategies to attain the goal:

1) Monitor contractual compliance with regard to prioritization of admission for pregnant women to substance use disorder treatment

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of pregnant women and women with dependent children served in substance use disorder treatment per fiscal year

Baseline Measurement: 6,497

First-year target/outcome measurement: 6,000

Second-year target/outcome measurement: 6,000

Data Source:

DMH Information Systems

Description of Data:

The number of pregnant women and women with dependent children served is capture in the DMH information system as individuals with at least one paid service for substance use disorder services and indicate pregnant during treatment, having dependent children or both.

Data issues/caveats that affect outcome measures:

None.

Priority #: 13

Priority Area: Early Serious Mental Illness and First Episode Psychosis

Priority Type: MHS, ESMI

Population(s): ESMI

Goal of the priority area:

To improve services for individuals experiencing ESMI and FEP by implementing Coordinated Specialty Care at CCBHO's and increasing access to other evidence informed practices supporting this population.

Strategies to attain the goal:

1) Establish a best practice center, Early Psychosis Care Center (EPC)
2) Engage CCBHO's and community partners to provide education about best practices supporting this ESMI/FEP population.
3) Provide data collection, analysis, and evaluation to inform services, supports, and sustainability.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Implementation of Coordinated Specialty Care Teams

Baseline Measurement: N/A

First-year target/outcome measurement: In Process

Second-year target/outcome measurement: Complete

Data Source:

Director of Young Adult Services

Description of Data:

Phases of Implementation of the CSC teams is overseen by the DMH Children's Office, Director of Young Adult Services.

Data issues/caveats that affect outcome measures:

None.

Indicator #: 2

Indicator: Number of individuals trained in First Episode Psychosis (FEP) best practices

Baseline Measurement: N/A

First-year target/outcome measurement: 500

Second-year target/outcome measurement: 600

Data Source:

DMH Children's Office

Description of Data:

Monitoring engagement is overseen by the Director of Youth Adult Services

Data issues/caveats that affect outcome measures:

None

Priority #: 14

Priority Area: Behavioral Health Services for Children

Priority Type: SUT, MHS

Population(s): SED, Other

Goal of the priority area:

To enhance children's behavioral health services by increasing knowledge of effective services, supports and interventions, enhancing the skills of service providers and expanding services based on the needs of the children, youth and families served.

Strategies to attain the goal:

1) Continue the statewide Children's Committee with standing agenda items for CSTAR or SUD treatment items. Committee will provide collaboration regarding issues of policy, training, treatment, funding, and outreach for adolescent substance use disorders.
2) Increase dissemination of research, best practices and success stories.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of SUD Committee meetings with adolescent focus

Baseline Measurement: 3

First-year target/outcome measurement: 3

Second-year target/outcome measurement: 3

Data Source:

DBH Children's Unit

Description of Data:

The number of meetings is tracked by the DMH Children's Unit staff

Data issues/caveats that affect outcome measures:

None.

Indicator #: 2

Indicator: Number of posts of articles, research, and stories specific to behavioral healthcare for children per fiscal year

Baseline Measurement: 36

First-year target/outcome measurement: 40

Second-year target/outcome measurement: 40

Data Source:

DBH Children's Unit

Description of Data:

The number of postings is tracked and reported by the DMH Children's Unit staff.

Data issues/caveats that affect outcome measures:

None.

Indicator #: 3

Indicator: The number of individuals served in adolescent substance use disorder treatment

Baseline Measurement: 2,119

First-year target/outcome measurement: 1,800

Second-year target/outcome measurement: 1,800

Data Source:

DMH Information Systems

Description of Data:

The number of individuas served in adolescent substance use disorder treatment is captured in the paid services in the DMH information system.

Data issues/caveats that affect outcome measures:

None.

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SUPTRS]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2024/2025.
SUPTRS BG – ONLY include funds expended by the executive branch agency administering the SUPTRS BG.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

Activity (See instructions for using Row 1.)	Source of Funds									
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)[a]	J. ARP Funds (SUPTRS BG)[b]
1. Substance Use Prevention[c] and Treatment	$43,548,051.00		$85,745,711.14	$72,936,623.88	$105,187,759.92	$0.00	$0.00		$1,368,659.31	$0.00
a. Pregnant Women and Women with Dependent Children[c]	$3,906,726.32		$4,825,144.22	$0.00	$8,122,189.76	$0.00	$0.00		$89,084.59	
b. Recovery Support Services	$1,600,000.00		$0.00	$20,370,888.00	$7,606,236.00	$0.00	$0.00		$580,654.15	
c. All Other	$38,041,324.68		$80,920,566.92	$52,565,735.88	$89,459,334.16	$0.00	$0.00		$698,920.57	
2. Primary Prevention[d]	$11,612,813.60		$0.00	$38,998,053.26	$10,273,108.02	$0.00	$0.00		$435,719.72	$0.00
a. Substance Use Primary Prevention	$11,612,813.60		$0.00	$38,998,053.26	$10,273,108.02	$0.00	$0.00		$435,719.72	
b. Mental Health Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Other Psychiatric Inpatient Care										
5. Tuberculosis Services	$0.00		$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	
6. Early Intervention Services for HIV	$0.00		$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	
7. State Hospital										
8. Other 24-Hour Care										
9. Ambulatory/Community Non-24 Hour Care										
10. Crisis Services (5 percent set-aside)										
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately	$2,903,203.40		$0.00	$6,387,649.00	$2,556,324.00	$0.00	$0.00		$0.00	
12. Total	**$58,064,068.00**	**$0.00**	**$85,745,711.14**	**$118,322,326.14**	**$118,017,191.94**	**$0.00**	**$0.00**	**$0.00**	**$1,804,379.03**	**$10,952,212.03**

[a] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 – June 30, 2025. Please enter SUPTRS BG ARP planned expenditures for the period of July 1, 2023 through June 30, 2025

[c] Prevention other than primary prevention

[d] The 20 percent set-aside funds in the SUPTRS BG must be used for activities designed to prevent substance misuse.

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Footnotes:
FFY 2024 SUPTRS BG, Medicaid, Other Federal, and State Funds have been adjusted for the 24 month planning period per the March 2022 revision request on last year's application.

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Table 2 addresses funds to be expended during the 24-month period of July 1, 2023 through June 30, 2025. Table 2 now includes columns to capture state expenditures for COVID-19 Relief Supplemental and ARP funds. Please use these columns to capture how much the state plans to expend over a 24-month period (July 1, 2023 - June 30, 2025). Please document the use of COVID-19 Relief Supplemental and ARP funds in the footnotes.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

Activity (See instructions for using Row 1.)	Source of Funds										
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)[a]	J. ARP Funds (MHBG)[b]	K. BSCA Funds (MHBG)[c]
1. Substance Use Prevention and Treatment											
a. Pregnant Women and Women with Dependent Children											
b. Recovery Support Services											
c. All Other											
2. Primary Prevention											
a. Substance Use Primary Prevention											
b. Mental Health Prevention[d]		$0.00	$0.00	$0.00	$414,335.96	$0.00	$0.00	$0.00		$1,291,404.29	
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[e]		$3,284,434.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	
4. Other Psychiatric Inpatient Care			$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	
5. Tuberculosis Services											
6. Early Intervention Services for HIV											
7. State Hospital			$0.00	$24,701,478.12	$517,869,736.22	$0.00	$0.00	$0.00		$0.00	
8. Other 24-Hour Care		$0.00	$0.00	$1,790,079.86	$11,190,831.44	$0.00	$0.00	$0.00		$0.00	
9. Ambulatory/Community Non-24 Hour Care		$26,275,473.90	$923,715,852.64	$30,323,925.89	$183,671,325.64	$0.00	$0.00	$169,331.69		$10,451,890.24	
10. Crisis Services (5 percent set-aside)[f]		$1,642,217.00	$0.00	$8,315,707.27	$42,871,604.00	$0.00	$0.00	$0.00		$3,909,974.91	
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately[g]		$1,642,271.10	$0.00	$1,363,094.46	$2,339,424.40	$0.00	$0.00	$0.00		$0.00	
12. Total	**$0.00**	**$32,844,396.00**	**$923,715,852.64**	**$66,494,285.60**	**$758,357,257.66**	**$0.00**	**$0.00**	**$169,331.69**	**$0.00**	**$15,653,269.44**	**$2,177,510.00**

[a]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states. Note: If your state has an approved no cost extension, you have until March 14, 2024, to expend the COVID-19 Relief supplemental funds.

[b]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[c]The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is from **October 17, 2022 thru October 16, 2024** and the expenditure for the 2nd allocation of BSCA funding will be from September 30, 2023 thru September 29, 2025 which is different from the expenditure period for the "standard" MHBG. Column J should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[d]While the state may use state or other funding for prevention services, the MHBG funds must be directed toward adults with SMI or children with SED.

[e]Column 3 should include Early Serious Mental Illness programs funded through MHBG set aside.

[f]Row 10 should include Behavioral Health Crisis Services (BHCS) programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

[g]Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

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Footnotes:
Mental Health Block Grant award amount doubled to reflect 24 month planning period. (per email from Ernest Fields on 5/24/22 for last year's application)

Planning Tables

Table 3 SUPTRS BG Persons in need/receipt of SUD treatment

To complete the Aggregate Number Estimated in Need column, please refer to the most recent edition of SAMHSA's National Survey on Drug Use and Health (NSDUH) or other federal/state data that describes the populations of focus in rows 1-5.

To complete the Aggregate Number in Treatment column, please refer to the most recent edition of the Treatment Episode Data Set (TEDS) data prepared and submitted to SAMHSA's Behavioral Health Services Information System (BHSIS).

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	7,500	579
2. Women with Dependent Children	47,000	7,561
3. Individuals with a co-occurring M/SUD	333,018	26,221
4. Persons who inject drugs	24,520	11,743
5. Persons experiencing homelessness	1,088	4,672

Please provide an explanation for any data cells for which the state does not have a data source.

Estimates for number in need for 1) pregnant women, 2) women with dependent children , and 3) individuals with a co-occurring M/SUD (any mental illness) are based on estimates from the National Survey on Drug Use and Health (2020). Estimated number in need for persons who inject drugs are based on prevalence estimates from Brady et al. (2008) (https://www.ncbi.nlm.nih.gov/pubmed/18344002). Estimated number in need for persons experiencing homelessness (point-in-time) are from the Housing and Urban Development (HUD) 2020 Continuum of Care Homeless Assistance Programs (https://files.hudexchange.info/reports/published/CoC_PopSub_State_MO_2022.pdf). Number in treatment for all cohorts reflect the number served in substance use disorder treatment by the Missouri Department of Mental Health, Division of Behavioral Health in SFY 2023.

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Footnotes:

Planning Tables

Table 4 SUPTRS BG Planned Expenditures

States must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations, including the supplemental COVID-19 and ARP funds. Plan Table 4 must be completed for the FFY 2024 and FFY 2025 SUPTRS BG awards. The totals for each Fiscal Year should match the President's Budget Allotment for the state.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	FFY 2024		
Expenditure Category	**FFY 2024 SUPTRS BG Award**	**COVID-19 Award[1]**	**ARP Award[2]**
1 . Substance Use Disorder Prevention and Treatment[3]	$20,974,026.00	$788,005.00	$2,448,048.00
2 . Substance Use Primary Prevention	$5,806,407.00	$435,720.00	$1,595,469.00
3 . Early Intervention Services for HIV[4]	$0.00	$0.00	$0.00
4 . Tuberculosis Services	$0.00	$0.00	$0.00
5 . Recovery Support Services[5]	$800,000.00	$580,654.00	$3,045,585.00
6 . Administration (SSA Level Only)	$1,451,601.00	$0.00	$0.00
7. Total	**$29,032,034.00**	**$1,804,379.00**	**$7,089,102.00**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19

Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the FY 2024 "standard" SUPTRS BG, which is October 1, 2023 - September 30, 2024. The SUPTRS BG ARP planned expenditures for the period of October 1, 2023 - September 30, 2024 should be entered here in the first ARP column, and the SUPTRS BG ARP planned expenditures for the period of October 1, 2024, through September 30, 2025, should be entered in the second ARP column.

[3]Prevention other than Primary Prevention

[4]For the purpose of determining which states and jurisdictions are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance use disorder Prevention and Treatment Block Grant (SUPTRS BG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the AtlasPlus HIV data report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP). The most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a “designated state” in any of the three years prior to the year for which a state is applying for SUPTRS BG funds with the flexibility to obligate and expend SUPTRS BG funds for EIS/HIV even though the state’s AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SUPTRS BG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance will be allowed to obligate and expend SUPTRS BG funds for EIS/HIV if they chose to do so and may elect to do so by providing written notification to the CSAT SPO as a part of the SUPTRS BG Application.

[5]This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023.

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Footnotes:

FFY 2024 SA Block Award: Amount of primary prevention funds planned for primary prevention programs (this amount should match the total reported in Table 5a and Table 5b) $4,974,604

FFY 2024 SA Block Award: Amount of primary prevention funds in Table 4, Line 2 that are planned for Prevention-SA resource development (this amount should not include funds reported in Table 5a or Table 5b) $831,803.00.

COVID-19 Award: Amount of primary prevention funds planned for primary prevention programs (this amount should match the total reported in Table 5a and Table 5b) $435,719.72.

COVID-19 Award: Amount of primary prevention funds in Table 4, Line 2 that are planned for Prevention-SA resource development (this amount should not include funds reported in Table 5a or Table 5b) $0.00

ARP Award: Amount of primary prevention funds planned for primary prevention programs (this amount should match the total reported in

Table 5a and Table 5b) $1,595,468.85.

ARP Award: Amount of primary prevention funds in Table 4, Line 2 that are planned for Prevention-SA resource development (this amount should not include funds reported in Table 5a or Table 5b) $0.00..

Planning Tables

Table 5a SUPTRS BG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

A		B		
Strategy	IOM Target	FFY 2024		
		SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
1. Information Dissemination	Universal	$336,816	$0	$0
	Selected	$51,548	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$388,364**	**$0**	**$0**
2. Education	Universal	$615,566	$0	$75,000
	Selected	$1,380,150	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$1,995,716**	**$0**	**$75,000**
3. Alternatives	Universal	$10,910	$0	$0
	Selected	$331,411	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$342,321**	**$0**	**$0**
4. Problem Identification and Referral	Universal	$0	$0	$0
	Selected	$0	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$0**	**$0**	**$0**
	Universal	$1,547,996	$435,720	$1,520,469

5. Community-Based Processes	Selected	$488,387	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$2,036,383**	**$435,720**	**$1,520,469**
6. Environmental	Universal	$10,409	$0	$0
	Selected	$5,766	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$16,175**	**$0**	**$0**
7. Section 1926 (Synar)-Tobacco	Universal	$0	$0	$0
	Selected	$0	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$0**	**$0**	**$0**
8. Other	Universal	$120,523	$0	$0
	Selected	$75,122	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$195,645**	**$0**	**$0**
Total Prevention Expenditures		**$4,974,604**	**$435,720**	**$1,595,469**
Total SUPTRS BG Award[3]		**$29,032,034**	**$1,804,379**	**$7,089,102**
Planned Primary Prevention Percentage		**17.13 %**	**24.15 %**	**22.51 %**

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

[3]Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

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Footnotes:

Planning Tables

Table 5b SUPTRS BG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Activity	FFY 2024 SUPTRS BG Award	FFY 2024 COVID-19 Award[1]	FFY 2024 ARP Award[2]
Universal Direct	$2,560,087	$435,720	$1,595,469
Universal Indirect	$82,133	$0	$0
Selected	$2,332,384	$0	$0
Indicated	$0	$0	$0
Column Total	**$4,974,604**	**$435,720**	**$1,595,469**
Total SUPTRS BG Award[3]	**$29,032,034**	**$1,804,379**	**$7,089,102**
Planned Primary Prevention Percentage	**17.13 %**	**24.15 %**	**22.51 %**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

[3]Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

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Footnotes:

Planning Tables

Table 5c SUPTRS BG Planned Primary Prevention Priorities (Required)

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2024 and FFY 2025 SUPTRS BG awards.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
Prioritized Substances			
Alcohol	☑	☑	☑
Tobacco	☑	☑	☑
Marijuana	☑	☑	☑
Prescription Drugs	☑	☑	☑
Cocaine	☐	☐	☐
Heroin	☑	☑	☑
Inhalants	☐	☐	☐
Methamphetamine	☑	☑	☑
Fentanyl	☑	☑	☑
Prioritized Populations			
Students in College	☑	☐	☐
Military Families	☐	☐	☐
LGBTQI+	☐	☐	☐
American Indians/Alaska Natives	☐	☐	☐
African American	☑	☑	☑
Hispanic	☐	☐	☐
Persons Experiencing Homelessness	☐	☐	☐
Native Hawaiian/Other Pacific Islanders	☐	☐	☐
Asian	☐	☐	☐
Rural	☑	☑	☑

Underserved Racial and Ethnic Minorities	☑	☐	☐

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

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Footnotes:

Planning Tables

Table 6 Non-Direct-Services/System Development [SUPTRS]

Please enter the total amount of the SUPTRS BG, COVID-19, or ARP funds expended for each activity.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Expenditure Category	FFY 2024				
	A. SUPTRS BG Treatment	B. SUPTRS BG Prevention	C. SUPTRS BG Integrated[1]	D. COVID-19[2]	E. ARP[3]
1. Information Systems	$0.00	$0.00	$0.00	$0.00	$0.00
2. Infrastructure Support	$0.00	$26,528.00	$0.00	$0.00	$891,507.18
3. Partnerships, community outreach, and needs assessment	$13,909.61	$755,275.00	$0.00	$0.00	$0.00
4. Planning Council Activities (MHBG required, SUPTRS BG optional)	$0.00	$0.00	$0.00	$0.00	$0.00
5. Quality Assurance and Improvement	$0.00	$0.00	$0.00	$0.00	$0.00
6. Research and Evaluation	$0.00	$0.00	$0.00	$0.00	$0.00
7. Training and Education	$0.00	$50,000.00	$0.00	$0.00	$0.00
8. Total	**$13,909.61**	**$831,803.00**	**$0.00**	**$0.00**	**$891,507.18**

[1]Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

[2]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[3]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the federal planned expenditure period of October 1, 2023 - September 30, 2025. Please list ARP planned expenditures for each standard FFY period.

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Footnotes:

Planning Tables

Table 6 Non-Direct-Services/System Development [MH]

Please enter the total amount of the MHBG, COVID-19, ARP funds, and BSCA funds expended for each activity

MHBG Planning Period Start Date: MHBG Planning Period End Date:

Activity	FY Block Grant	FY [1] COVID Funds	FY [2] ARP Funds	FY [3] BSCA Funds
.	$	$	$	$
8. Total			**$**	**$**

Please wait while data loads...

[1] The 24-month expenditure period for the COVID-19 Rel **21 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Per the ins res captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for mo oved no cost extension, you have until March 14, 2024 to expend the COVID-19 Relief supplemental funds.

[2] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for most states.

[3] The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is **October 17, 2022** thru **October 16, 2024** and for the 2nd allocation will be **September 30, 2023** thru **September 29, 2025** which is different from the expenditure period for the "standard" MHBG. Column D should reflect the spending for the state reporting period. The total may reflect the BSCA allotment portion used during the state reporting period.

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Footnotes:

Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required

Narrative Question

Across the United States, significant percentages of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not access needed behavioral health care. States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **https://store.samhsa.gov/product/essential-aspects-of-parity-training-tool-for-policymakers/pep21-05-00-001**; **https://store.samhsa.gov/product/Approaches-in-Implementing-the-Mental-Health-Parity-and-Addiction-Equity-Act-Best-Practices-from-the-States/SMA16-4983**. The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1]Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in and efficient and effective manner. States should develop systems that vary the intensity of care coordination support based on the severity seriousness and complexity of individual need. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

[1]Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Medical care, 599-604.Avaiable at: **https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx**

1. Describe your state's efforts to improve access to care for mental disorders, substance use disorders, and co-occurring disorders, including detail on efforts to increase access to services for:

a) Adults with serious mental illness

b) Pregnant women with substance use disorders

c) Women with substance use disorders who have dependent children

d) Persons who inject drugs

e) Persons with substance use disorders who have, or are at risk for, HIV or TB

f) Persons with substance use disorders in the justice system

g) Persons using substances who are at risk for overdose or suicide

h) Other adults with substance use disorders

i) Children and youth with serious emotional disturbances or substance use disorders

j) Individuals with co-occurring mental and substance use disorders

A. The Community Mental Health Centers (CMHCs) & Federally Qualified Health Centers (FQHCs) Integration Initiative allows CMHCs and FQHCs to partner. The goals of the integration initiative supports collaboration between CMHCs and FQHCs to integrate behavioral health services and primary care in the public health safety net system in order to improve access to: primary care for individuals with mental illness; behavioral health services for individuals with previously unrecognized and/or untreated mental health problems; and behavioral health supports for individuals who require assistance in effectively managing their chronic disease or improving health status.

B. The Division of Behavioral Health (DBH) staff meet monthly with providers of women and children substance use programming and tour provider locations throughout the state. Meetings focus on increasing partnerships within the community to meet the needs of individuals, technical assistance to remove barriers to service delivery, and ways to improve quality of services.

C. The DBH staff meet monthly with providers of women and children substance use programming and tour provider locations throughout the state. Meetings focus on increasing partnerships within the community to meet the needs of individuals served, technical assistance to remove barriers to service delivery, and ways to improve quality of services.

D. Individuals who inject drugs continue to be a priority population and providers are contractually expected to meet the needs of this population with timely access.

E. Individuals with HIV and TB or at-risk for HIV or TB continue to be a priority population and providers and contractually expected to meet the needs of this population with timely access.

F. In 2018, the Department of Corrections (DOC) was appropriated funds to establish and implement a community behavioral health program to provide comprehensive community-based services for individuals under the supervision of DOC who have substance use disorders (SUD) and/or co-occurring substance use disorders and mild to moderate mental illness and are considered high risk for reoffending. DOC Probation and Parole (P&P) staff work together on a team with local behavioral health treatment and recovery providers to ensure individuals on supervision who are at high risk of reoffending and have behavioral health needs receive individualized evidence-based treatment in the community.

G. Since its national launch in July of 2022, the 988 Suicide & Crisis Lifeline has played a vital role in providing rapid access to crisis services for individuals experiencing mental health, suicide, or substance use crises. In Missouri, DMH, behavioral health providers, and community partners have been working diligently to establish a comprehensive "no-wrong-door" integrated crisis response system. This collaborative effort aims to prevent tragedies, save lives, and optimize resource utilization. Missouri's vision is to build an evidence-based care continuum to deliver high-quality community-based crisis services statewide with the 988 at its core. 988 as a core component of our behavioral health crisis system enhances access to timely and effective support and coordination and connection to ongoing care, including substance use-specific resources, for those reaching out.

H. The SUD Provider & FQHC Integrated Care Project allows Behavioral Health Providers contracted by DBH to provide CSTAR services and FQHCs to partner. The goals of the project support collaboration between FQHCs and DMH Certified CSTAR Providers to integrate primary care and substance use treatment in the public health safety net system in order to: identify substance use concerns within the primary care environment; reduce health disparities; and change (improve, create) the working relationship between primary medical and specialty behavioral health.

I. To enhance collaborative, community-based services provided to youth and to improve access to mental health services DMH has worked with CMHC/Certified Community Behavioral Health Organizations (CCBHO) providers to establish Youth Behavioral Health Liaisons (YBHL). An YBHL is a mental health professional who forms local community partnerships with various youth-serving organizations to address specific behavioral health needs of vulnerable children and youth. The YBHL functions as a service connector for children and youth with co-occurring mental illness, substance use and/or developmental disability to link services available through community partners. A primary goal in establishing YBHL's is to form better community partnerships between CMHCs, CCBHOs, and SUD treatment providers with the Juvenile Office, Family Courts, Children's Division, and hospitals to help improve outcomes for children and youth with behavioral health issues. YBHL's work to divert children and youth from inpatient hospitalization and out-of-home placements such as residential treatment centers and juvenile detention, while supporting children and youth in natural family or community-based settings. Through their interactions with the YBHL's children and youth and families with behavioral health issues, substance use disorders, and developmental disabilities who have frequent interaction with Children's Division, Juvenile and Family Courts, law enforcement, and inpatient hospitals will have improved access to behavioral health treatment.

J. A wide array of DMH supported SUD treatment and mental illness support services are located across the state. DBH has developed treatment programs that focus on providing a complete continuum of services, including extended outpatient services in the community and close to home where possible. Individualized service packages are offered to provide Missourians with ready access to treatment and to assist them in achieving and maintaining recovery from substance use and receive psychiatric services in the community in which they live.

2. Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance parity enforcement and increase awareness of parity protections among the public and across the behavioral and general health care fields.

The DMH partnered with the Missouri Medicaid division, MoHealthNet (MHD), to apply the parity rule, which ensures that limitations on mental health and substance use disorder (MH/SUD) services are not more restrictive than limitations on

medical/surgical (M/S) services. Aggregate lifetime and annual dollar limits are limits on the total dollar amount a Medicaid program will pay for specified benefits over a beneficiary's lifetime or on an annual basis. These limits cannot be applied to MH/SUD benefits unless they apply to at least one third of all M/S benefits. In addition, limits must either be applied to both M/S and MH/SUD benefits as a whole or the limits applicable to MH/SUD benefits must be no more restrictive than those for M/S benefits. Financial requirements (FRs) and quantitative treatment limitations (QTLs) for MH/SUD benefits within a classification may not be more restrictive than the predominant FR or QTL applicable to substantially all medical/surgical benefits in that classification.

To this end, contracts with managed care organizations regarding the health plans were amended to include the following:
1. Compliance with the Wellstone – Domenici Mental Health Parity and Addiction Equality Act of 2008;
2. Prohibited from requiring prior authorization for in-network behavioral health services unless approved in advance by the state agency in writing; and
3. provide reports documenting compliance with Mental Health Parity and Addiction Equality Act to the state agency

The original report for this effort can be found here: https://dss.mo.gov/mhd/mc/pdf/mental-health-parity-compliance.pdf.

3. Describe how the state supports integrated behavioral health and primary health care, including services for individuals with mental disorders, substance use disorders, and co-occurring mental and substance use disorders. Include detail about:

a) Access to behavioral health care facilitated through primary care providers

b) Efforts to improve behavioral health care provided by primary care providers

c) Efforts to integrate primary care into behavioral health settings

Behavioral Health Homes: The Health Home under the Affordable Care Act is an alternative approach to the delivery of health care services and better health outcomes than traditional care. The Behavioral Health Home has many characteristics of the Patient Centered Medical Home but is customized to meet the specific needs of adults with serious mental illness (SMI) and children/youth with serious emotional disturbance (SED) who often have other co-occurring chronic medical illnesses. Missouri's initiative enhances the existing psychiatric rehabilitation program by adding Nurse Care Managers and Specialized Healthcare Consultant to each CMHC and CCBHO. Additionally, it gives the enhanced psychiatric rehabilitation team access to a wealth of care management reports designed to help them both identify treatment gaps and to assist individuals in developing healthy lifestyles and managing their chronic illnesses. Goals of the Behavioral Health Home initiative are to reduce unnecessary hospitalization and emergency room visits, while improving the health status of the individuals enrolled in the program. Missouri's plan was approved by the Centers for Medicare and Medicaid Services (CMS) in October 2011. Implementation began in January 2012. Under Missouri's plan, 26 CMHCs/CCBHOs are contracted as Behavioral Health Home providers. For an individual to be eligible for enrollment in Missouri's Behavioral Health Home, they must meet one of the following three conditions: 1) have a serious and persistent mental illness, 2) have a mental health condition and a substance use disorder, or 3) have a mental health condition or a substance use disorder and one other chronic health condition. In FY 2019, Missouri began developing State Plan Amendment language to include complex trauma as a qualifying chronic condition.

Disease Management 3700 (DM 3700) & SUD Disease Management (SUD DM): The Disease Management programs are a result of collaboration between the Department of Mental Health (DMH) and the Missouri Medicaid agency, MO HealthNet. DM 3700 was implemented in November 2010 and targets Medicaid-enrolled adults with a serious mental illness and high Medicaid costs who are currently not engaged in services at a DMH-contracted agency. The SUD DM project was implemented in February 2014. SUD DM targets Medicaid-enrolled adults with substance use disorders and high Medicaid costs who are not currently engaged in at a DMH-contracted agency. DMH funds outreach efforts and MO HealthNet funds behavioral health treatment for those enrolled in the program. Behavioral Health Home providers also participate in the DM 3700 program. Seventeen CSTAR providers (i.e., Missouri's only Medicaid reimbursable substance use disorder program) participate in the SUD DM project. Each provider added a nurse liaison to assist with care coordination of complex physical health conditions of program participants. DMH and community partners meet regularly to discuss implementation and quality improvement of the Behavioral Health Homes, DM 3700 and SUD DM programs.

Certified Community Behavioral Health Organizations were developed from the Excellence in Mental Health Act sponsored by Senator Roy Blunt. It establishes for community behavioral health providers a place in federal statute, nation standards and cost related reimbursement. Missouri was one of eight states selected to participate in the CCBHC demonstration project that was initially a two-year grant; however, was recently extended until September 30, 2025. Missouri has 22 CCBHOs covering all of Missouri 114 counties. CCBHO requirements include serving designated populations of focus including children/youth and adults with moderate to severe mental illness, adolescents and adults with moderate to severe substance use disorders, children/youth in state custody who have behavioral health disorders, and veterans or members of the armed forces with a behavioral health diagnosis. CCBHOs are required to:
• Serve the populations of focus regardless of an individual's ability to pay, place of residence, homelessness, or lack of a permanent address;
• Use evidence- based, best and promising practices;
• Coordinate care and provide a comprehensives array of community behavioral health services;
• Provide needed services to the populations of focus regardless of payment source or ability to pay;
• Measure and report outcomes on efficiency and effectiveness or services provided and health status of individuals served;
• Provide comprehensive array of behavioral health services;
• Primary care screening and monitoring;

• Case management;
• Psychiatric rehabilitation; and
• Peer and family support services.

The Emergency Room Enhancement (ERE) program is one component of the Strengthening Missouri's Mental Health System initiative approved by Governor Jay Nixon in 2013. The purpose of the ERE program is to engage specific individuals into ongoing treatment. ERE coordinates care for the whole person by addressing behavioral health, physical health and basic needs. ERE goals also include reducing the need for future emergency visits, hospitalizations and reducing hospital stays. DMH provides funding to 18 regions across the state for the program, encompassing all of Missouri's 114 counties. Each of the 18 regions have partnered with local hospitals, community health centers, law enforcement agencies, substance use treatment providers, and social service providers to coordinate care and remove barriers to individuals seeking treatment and services.

4. Describe how the state provides care coordination, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:

a) Adults with serious mental illness

b) Adults with substance use disorders

c) Children and youth with serious emotional disturbances or substance use disorders

The state supports a service system that provides health home services for individuals with co-occurring mental illness and physical health needs to include use of a Specialized Healthcare Consultant and Nurse Care Manager who ensure physical health needs are met for adults with serious mental illness and children/youth with serious emotional disturbance. Behavioral Health home providers receive either receive a per member per month payment from the CMHC or a Prospective Payment System (PPS) payment from the CCBHO to conduct metabolic screenings, determine individual needs, and coordinate both mental and physical healthcare for individuals served in the Behavioral Health Home. Providers implementing the evidence-based practice, Integrated Treatment for Co-occurring Disorders (ITCD), have access to additional service codes within the Medicaid rehab option program. Additionally, the state conducts fidelity reviews to ensure programs are following the evidenced model.

The state also supports a service system that provides integrated treatment for through CCBHOs. The Centers for Medicare and Medicaid (CMS) have established guidelines for implementing a Prospective Payment System to purchase services from CCBHOs. The PPS is a cost-based reimbursement which establishes a cost per visit for each CCBHO based on audited costs and proposed costs vs actual and proposed visits. A "visit" is a day in which an eligible individual receives an eligible service either face-to-face or via telehealth from an eligible provider. CCBHOs receive the same reimbursement regardless of the number of services provided during a visit. Missouri supports a service system that provides Wellness Coaching for individuals with co-occurring mental illness or substance use disorder and physical health conditions. Wellness Coaching is a deliberate process using a set of techniques designed to focus on achieving or maintaining wellness. A Wellness Coach assists individuals in meeting their wellness goals by helping individuals clarify what they want to change or improve and guides the individual toward long lasting behavioral change by providing ongoing support and reinforcement.

DMH partners and coordinates with the Missouri Primary Care Association, Missouri Hospital Association and Rural Health Association in order to increase communication and support each other through initiatives.

In July of 2022, the Comprehensive Substance Treatment and Rehabilitation (CSTAR) state plan amendment was approved allowing the DBH to transform substance use programming to be a medical-focused, evidence-based, outcomes-driven model of care by incorporating the American Society of Addiction Medicine (ASAM) criteria, reducing fee for service reimbursement methodology, and embracing a team based approach, to better address substance use as a chronic care model and improve availability of evidence based practices throughout the service array.

5. Describe how the state supports the provision of integrated services and supports for individuals with co-occurring mental and substance use disorders, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

CCBHOs require that agencies have on-site SUD services or contract with SUD providers for individuals with co-occurring disorders. Primary Care Health Homes require youth are screened for SUD so they can be provided brief interventions or referral to treatment—possibly by a behavioral health consultant at primary care agency.

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

2. Health Disparities - Required

Narrative Question

In accordance with Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (Executive Order 13985), Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals (Executive Order 14075), the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[1], **Healthy People, 2030**[2], **National Stakeholder Strategy for Achieving Health Equity**[3], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual orientations, gender identities, races, and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (e.g., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the **Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[4].

Collecting appropriate data are a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[5]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[6]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQI+ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. In addition, LGBTQI+ individuals are at higher risk for suicidality due to discrimination, mistreatment, and stigmatization in society. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

[1] **https://www.minorityhealth.hhs.gov/assets/pdf/hhs/HHS_Plan_complete.pdf**

[2] **https://health.gov/healthypeople**

[3] **https://www.mih.ohio.gov/Portals/0/Documents/CompleteNSS.pdf**

[4] **https://thinkculturalhealth.hhs.gov/**

[5] **https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status**

[6] **https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf**

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

a) Race	◉ Yes	○ No
b) Ethnicity	○ Yes	◉ No
c) Gender	◉ Yes	○ No
d) Sexual orientation	○ Yes	◉ No
e) Gender identity	○ Yes	◉ No
f) Age	◉ Yes	○ No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? ○ Yes ◉ No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? ◉ Yes ○ No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? ◉ Yes ○ No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards? ○ Yes ◉ No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? ◉ Yes ○ No

7. Does the state have any activities related to this section that you would like to highlight?

The Department of Mental Health (DMH) is taking a critical look at its policies, practices, and outcomes. The goal is to understand where the system is currently, and to take action to enhance equity in Missouri's public mental health system. The Mental Health and Inclusion Alliance (Alliance) was established to support the DMH in actualizing and fulfilling its commitment to equitable access, inclusive services, and favorable outcomes for the individuals it serves. Mental Health Equity is the right to access quality mental health services for all populations. It is a structural and systemic concept that focuses on achieving comparable, favorable outcomes across racial and other groups through the allocation of resources in ways designed to remedy disadvantages some individuals face through no fault of their own. The Alliance aims to help DMH and its provider network achieve and sustain equity by promoting fairness in policies, programs, initiatives, hiring and promotion practices, funding decisions, and outcomes. To achieve these objectives the Alliance will aid in the effort to advance and embed equity and inclusion principles and practices in the mental health system. In addition, empowering disadvantaged populations and stakeholders to participate in service system design and delivery, as well as policy development, is necessary. The members of the Alliance will deliver and help implement a Mental Health Equity and Inclusion Plan. Areas of focus include initiatives, hiring and promotion practices, funding decisions, and outcomes for individuals served. More information is available online at: https://dmh.mo.gov/mental-health-equity-and-inclusion-alliance.

The Division of Behavioral Health (DBH), through the use of data, has taken steps to identify geographic area with high need and low resources. Through the utilization of the data the DBH has identified North St. Louis City and County as the geographic area most in need. The identified area continues to have a disproportionately high number of opioid overdose deaths within a predominantly African American community. In addition to the high level of acuity and death rates, North St. Louis City and County contained the largest gap in services available to identify and treat these high needs. To address these concerns, the DBH has supported community focused outreach and engagement, prevention and education, as well as additional treatment and recovery support services in this area. This effort utilizes local community grassroots organizations, whose members live and work within these communities, to provide greater outreach and engagement services within their respective communities. These grassroots organizations have worked together to form GROW- STL (Grassroots Reinvestment for Optimal Wellbeing of St. Louis). In the first year of operation, GROW-STL partners outreached 4,393 unique individuals with a SUD, with 1,450 of those reporting an Opioid Use Disorder (OUD) concern. GROW-STL partners were able to engage and refer 414 individuals to SUD treatment providers and an additional 938 individuals were connected to Recovery Support Services. All of these individuals reside in zip codes with the highest acuity and death rates from an opioid overdose in Missouri. Recently, Missouri has seen a significant increase in the number of individuals using Xylazine and in significant need of wound care services. Through a partnership with local Federally Qualified Health Centers (FQHCs) and the GROW-STL providers, identified individuals will now be able to access wound care during community outreach efforts, which include the distribution of Narcan.

The DBH Metro East regional staff have been working with local St. Louis behavioral health providers to address diversity, equity, and inclusion within their organizations and service delivery systems. A number of meetings and trainings have been held to address individual engagement in treatment from a diversity, equity, and inclusion (DEI) perspective. Metro East providers have been attending “Lets Connect” meetings to openly discuss DEI concerns, both within their organizations, and as it relates to the individual’s experience. Members of GROW-STL and providers of Recovery Support Services are openly sharing perspectives of individuals served on the experiences of diverse individuals from admission to discharge with the DBH Regional staff and local behavioral health providers. The Behavioral Health providers have been open to these discussions, and are actively implementing changes within their organizations to improve the individual’s experience. As a result of these changes, many providers are

reporting better engagement rates, which equates to better outcomes and experiences for individuals served. In addition to “Let’s Connect” in the Metro East Region, the DBH is working closely with the Missouri Behavioral Health Council’s Culture, Equity, Diversity & Inclusion committee in actively providing education and supports to behavioral health providers across the state.

Please indicate areas of technical assistance needed related to this section

Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, (**V = Q ÷ C**)

SAMHSA anticipates that the movement toward value-based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services. The **National Center of Excellence for Integrated Health Solutions**[1] offers technical assistance and resources on value-based purchasing models including capitation, shared-savings, bundled payments, pay for performance, and incentivizing outcomes.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence for the efficacy and value of various mental and substance use prevention, SUD treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM/NASEM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center (EBPRC) assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's EBPRC provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions used with individuals with mental illness and substance use disorders, including youth and adults with substance use disorders, adults with SMI, and children and youth with SED. The recommendations build on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[2], The New Freedom Commission on Mental Health[3], the IOM, NQF, and the **Interdepartmental Serious Mental Illness Coordinating Committee** (ISMICC)[4].

One activity of the EBPRC[5] was a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[6] SAMHSA and other HHS federal partners, including the Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many innovative and promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, evidence is collected to determine their efficacy and develop a more detailed understanding of for who and in what circumstances they are most effective.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[7] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[8] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. Each KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice

demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, for educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is interested with what additional information is needed by SMHAs and SSAs to support their and other purchasers' decisions regarding value-based purchase of M/SUD services.

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[1] **https://www.thenationalcouncil.org/program/center-of-excellence/**

[2] United States Public Health Service Office of the Surgeon General (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[3] The President's New Freedom Commission on Mental Health (July 2003). *Achieving the Promise: Transforming Mental Health Care in America*. Rockville, MD: Department of Health and Human Services, Substance use disorder and Mental Health Services Administration.

[4] National Quality Forum (2007). *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices*. Washington, DC: National Quality Forum.

[5] **https://www.samhsa.gov/ebp-resource-center/about**

[6] **http://psychiatryonline.org/**

[7] **http://store.samhsa.gov**

[8] **https://store.samhsa.gov/?f%5B0%5D=series%3A5558**

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? (●) Yes ( ) No

2. Which value based purchasing strategies do you use in your state (check all that apply):

- **a)** ☑ Leadership support, including investment of human and financial resources.
- **b)** ☑ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- **c)** ☑ Use of financial and non-financial incentives for providers or consumers.
- **d)** ☑ Provider involvement in planning value-based purchasing.
- **e)** ☑ Use of accurate and reliable measures of quality in payment arrangements.
- **f)** ☑ Quality measures focused on consumer outcomes rather than care processes.
- **g)** ☑ Involvement in CMS or commercial insurance value-based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
- **h)** ☑ The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

Missouri was chosen as a Certified Community Behavioral Health Organization (CCBHO) demonstration state with an implementation date of July 1, 2017. The CCBHO Demonstration grant was extended to September 2025. There are 22 CCBHOs participating in the demonstration project covering all 114 of Missouri's counties. A State Plan Amendment (SPA) was submitted to the Centers for Medicare and Medicaid Services (CMS) and was approved to continue the Perspective Payment System (PPS). Incentive payments, quality measures and a focus on outcomes are all key components of providing services as a CCBHO. Missouri specifically chose evidence-based and promising practices as requirements for CCBHO inclusion, which include: medication assisted treatment (MAT), peer and family supports, and integrated treatment for co-occurring disorders (ITCD), among others.

In 2018, the Department of Corrections (DOC) was appropriated funds and collaborated with DMH to implement a comprehensive, community-based program for individuals under the supervision of DOC who have a substance use disorder, co-occurring disorders, and/or mild to moderate mental illness, and are considered high risk for reoffending. The Improving Community Treatment Success (ICTS) program is unique in that it provides quarterly incentive payments to community behavioral health providers based on agreed-upon outcome measures to improve recovery and recidivism outcomes. Metrics include: retention in treatment; stable employment; stable housing; reduced probation revocations; and reduced substance use violations.

The Division of Behavioral Health (DBH) submitted a New Decision Item for this year's state budget for Value-Based Payments for Recovery Support Service Providers. The Value-Based Payment for recovery support services incentivizes completion of a new assessment for measuring recovery capital. Providers receive a payment based on initial entry of data in a web-based platform and follow-up assessments. The budget item was approved and progress is being made on implementation.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Please name the model(s) that the state implemented including the number of programs for each model for those with ESMI using MHBG funds.

Model(s)/EBP(s) for ESMI/FEP	Number of programs
Coordinated Specialty Care - NAVIGATE	2

2. Please provide the total budget/planned expenditure for ESMI/FEP for FY 24 and FY 25 (only include MHBG funds).

FY2024	FY2025
1642218	1642218

3. Please describe the status of billing Medicaid or other insurances for ESMI/FEP services? How are components of the model currently being billed? Please explain.

The Department of Mental Health (DMH) is providing MHBG-FEP-SET aside funding to start-up two teams. During the start-up period, these agencies will work to establish sustainable services and eventually build in and bill for these costs as a Prospective payment system (PPS) due to being a Certified Community Behavioral Health Organization (CCBHO).

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI/FEP.

Missouri has recently developed a partnership with Missouri Institute of Mental Health (MIMH) to form Missouri's Early Psychosis Care (EPC) Center. This statewide resource and partnership allows DMH to reach all community stakeholders in order to raise awareness, provide trainings, and engage individuals with lived experience to help inform stakeholders on best practices, trends, and strategies to effectively support this population. Example trainings and learning opportunities for community behavioral health providers and all stakeholders, including individuals with lived FEP experience and their family members, include, but not limited to, Psychosis 101, Assessment 101, video-based learning, newsletters, annual EPC conference, consultation, networking events, and children/youth and family advisory council. Once CSC programs are established the EPC will provide technical assistance and fidelity for the CSC Teams.

5. Does the state monitor fidelity of the chosen EBP(s)?

(●) Yes ( ) No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI/FEP?

(●) Yes ( ) No

7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI/FEP?

Much of the EPC education highlights the importance of early identification and intervention. Behavioral Health Providers understand when individuals have access to early intervention it helps reduce future episodes, shortens the duration of psychosis, and can prevent future episodes. EPC offers resources and support to CCBHOs which works to build capacity for FEP services across the state.

8. Please describe the planned activities for FY 2024 and FY 2025 for your state's ESMI/FEP programs.

EPC will continue to provide education, awareness, trainings, presentations, conferences, networking events, consultation, and to build the child/youth and family advisory council. Two CSC teams using the NAVIGATE model are expected to come online Fall 2023 and EPC Center will provide fidelity and consultation using the NAVIGATE trainers and consultants.

9. Please list the diagnostic categories identified for your state's ESMI/FEP programs.

CSC NAVIGATE Criteria:
1. Diagnosis of schizophrenia and schizoaffective disorder;
2. Age 15 to 40;
3. Have had one year or less of antipsychotic medications;
4. Do not have autism;
5. Do not have intellectual disability;
5. Do not have traumatic brain injury; and
6. That substance-induced psychosis is not sufficient to meet criteria. They need to have schizophrenia or schizoaffective disorder in addition. If they are not using substances and still have psychosis, they meet criteria.

10. What is the estimated incidence of individuals with a first episode psychosis in the state?

The workforce calculator estimates the incidence of FEP between 0.02%-0.03% per year, for the total population. In Missouri, this results in an estimated annual incidence of FEP of 1,231 – 1,846 cases per year. The workforce calculator also estimates that only a fraction of these cases, ranging from 20% – 50% will actually be approached by a CSC team in any given region, resulting in a range of 308-923 (Low-High estimate) individuals approached in any given year.

11. What is the state's plan to outreach and engage those with a first episode psychosis who need support from the public mental health system?

The EPC provides resources and support for CCBHOs and Community Mental Health Centers to outreach and engage individuals with a first episode psychosis. The EPC also offers resources, support, and education to additional stakeholders including law enforcement, school personnel, primary care physicians, and more. The EPC also will provide fidelity reviews for the two CSC teams and be able to offer support and technical assistance to help keep outreach a focus for services.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required for MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. Resources for assessing and developing PCP systems can be found at the National Center on Advancing Person-Centered Practices and Systems **https://ncapps.acl.gov/home.html** with a systems assessment at **https://ncapps.acl.gov/docs/NCAPPS_SelfAssessment_201030.pdf**

1. Does your state have policies related to person centered planning? (●) Yes ( ) No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

Individuals and their caregivers are engaged through an individualized assessment and treatment planning processes that focus on recovery needs and preferences of the individual in all areas of life. The behavioral health provider conducts active dialogue with the individual in order to know what the individual's needs and desires are in life to provide an array of services that would best help them reach their goals.

4. Describe the person-centered planning process in your state.

The expectation is that behavioral health providers meet with the individual and the family/natural supports to assess their treatment needs and develop the recovery goals that the individual wants while offering service interventions that can help the individual achieve said goals. The treatment team provides input and develops a written treatment plan that is reviewed by the individual and the individual receives a copy. The expectation is that the treatment plan is revised and updated in an ongoing manner to reflect achievement of goals/objectives and the addition of any new goals/objectives throughout the year. In efforts to enhance the quality of person-centered planning the Division of Behavioral Health continues to streamline assessment processes. More time is allowed for development of the person-centered plan so the behavioral health providers have more time to become familiar with the individuals and understand their needs. Requirements for an annual assessment have been reduced to lessen the burden for individuals, better promote early engagement in services, and allow behavioral health service providers more time to focus on treatment needs rather than documentation.

5. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as SAMHSA's **A Practical Guide to Psychiatric Advance Directives**)?"

Each individual served shall receive an orientation about what to expect while receiving services and the individual's role in treatment. The orientation shall include but is not limited to education regarding advance directives.

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x–5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SUPTRS BG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SUPTRS BG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SUPTRS BG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based, culturally competent programs, substance use primary prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SUPTRS BG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? (●) Yes ( ) No

3. Does the state have any activities related to this section that you would like to highlight?

The Division of Behavioral Health (DBH) implemented an annual SABG monitoring of DBH contracted providers. The DBH has checks and balances to ensure Block Grant funds are spent appropriately. This includes maintaining a menu of services that may be provided, setting up controls within the billing portal and to ensure accurate billing. A comprehensive system is in place between clinical, fiscal, and monitoring entities within the DBH to ensure contract compliance. The billing system allows DBH to run utilization reports that are used to identify and correct any areas of concern. The DBH also collects data from Behavioral Health Providers for block grant reporting.

Please indicate areas of technical assistance needed related to this section

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Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[56] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

2. What specific concerns were raised during the consultation session(s) noted above?

3. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Missouri does not have any federally recognized tribes.

Environmental Factors and Plan

8. Primary Prevention - Required SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? (●) Yes ( ) No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) (●) Yes ( ) No

- **a)** [x] Data on consequences of substance-using behaviors
- **b)** [x] Substance-using behaviors
- **c)** [x] Intervening variables (including risk and protective factors)
- **d)** [ ] Other (please list)

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- **a)** [x] Children (under age 12)
- **b)** [x] Youth (ages 12-17)
- **c)** [x] Young adults/college age (ages 18-26)
- **d)** [x] Adults (ages 27-54)
- **e)** [x] Older adults (age 55 and above)
- **f)** [x] Cultural/ethnic minorities
- **g)** [x] Sexual/gender minorities
- **h)** [x] Rural communities
- **i)** [ ] Others (please list)

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

- **a)** ☐ Archival indicators (Please list)
- **b)** ☑ National survey on Drug Use and Health (NSDUH)
- **c)** ☑ Behavioral Risk Factor Surveillance System (BRFSS)
- **d)** ☑ Youth Risk Behavioral Surveillance System (YRBS)
- **e)** ☐ Monitoring the Future
- **f)** ☐ Communities that Care
- **g)** ☑ State - developed survey instrument
- **h)** ☐ Others (please list)

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? ◉ Yes ○ No

- **a)** If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?

  The Division of Behavioral Health (DBH) supports various targeted initiatives in the state based on need. Prevention providers must submit an annual Strategic Work Plan using the Strategic Prevention Framework. As part of the plan they must conduct a community needs assessment and coalition assessments. Based on their assessments, the providers choose the top priorities to work on for the planning year. Examples of targeted initiatives include education on alcohol, tobacco, marijuana, prescription drug misuse, mentoring programs for at-risk youth, and after school programs for at-risk youth.
- **b)** If no, (please explain) how SUPTRS BG funds are allocated:

6. Does your state integrate the National CLAS standards into the assessment step? ◉ Yes ○ No

- **a)** If yes, please explain in the box below.

  Lack of data for LGBTQ+ population is a state identified data gap. In 2018, the DBH asked schools to allow us to put a sexual orientation and a gender identity question on the Missouri Student Survey. Some schools opted in, however in the one district opted in, parents became upset, and this became a statewide news issue. In 2020 and 2022, the DBH decided to continue to ask schools to opt-in to these questions, some schools did allow DBH to add the questions. Requesting data for LGBTQ+ population is a method for gathering preliminary data, however it also allows communities the opportunity to discuss a regional taboo topic in this area of the country.
- **b)** If no, please explain in the box below.

7. Does your state integrate sustainability into the assessment step? ◉ Yes ○ No

- **a)** If yes, please explain in the box below.

  Sustainability is a part of the goal for each step.
- **b)** If no, please explain in the box below.

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Planning

1. Does your state have a statewide licensing or certification program for the substance use primary prevention workforce? (●) Yes ( ) No

a) If yes, please describe.

DBH and the Missouri Credentialing Board worked together to establish a three-tiered credentialing process to reach the entire spectrum of prevention professionals. All three levels of credentialing are marked by training, experience, and education. DBH requires that all contracted prevention providers obtain at least the first credential level.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use primary prevention workforce? (●) Yes ( ) No

a) If yes, please describe mechanism used.

DBH provides technical assistance and training to contracted prevention providers. Training needs are assessed across the state and necessary assistance to help prevention staff and programs is provided for them to be successful.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? (●) Yes ( ) No

a) If yes, please describe mechanism used.

Primary Prevention providers are required to assess the community readiness as a part of their annual Strategic Work Plan. The providers use the Tri-Ethnic Center Community Readiness Survey.

4. Does your state integrate the National CLAS Standards into the capacity building step? (●) Yes ( ) No

a) If yes, please explain in the box below.

Lack of data for LGBTQ+ population is a state identified data gap. In 2018, we asked schools to allow us to put a sexual orientation and a gender identity question on the Missouri Student Survey. Some schools opted in but in one district that did chose to opt in, parents became upset, and this became a statewide (and even some out of state) news issue. In 2020 and 2022, we decided to continue to ask schools to opt-in to these questions. Again, some schools did allow us to add the questions. It is a way to gather preliminary data, but it is also a way to allow our communities time to get used to talking about what is often a forbidden topic in this area of the country.

5. Does your state integrate sustainability into the capacity building step? (●) Yes ( ) No

a) If yes, please explain in the box below.

Sustainability is a part of the goal for each step.

b) If no, please explain in the box below.

Narratve Question

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use primary prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan.

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SUPTRS BG? (●) Yes ( ) No ( ) N/A

3. Does your state's prevention strategic plan include the following components? (check all that apply):

- **a)** [x] Based on needs assessment datasets the priorities that guide the allocation of SUPTRS BG primary prevention funds
- **b)** [x] Timelines
- **c)** [x] Roles and responsibilities
- **d)** [x] Process indicators
- **e)** [x] Outcome indicators
- **f)** [x] Cultural competence component (i.e., National CLAS Standards)
- **g)** [x] Sustainability component
- **h)** [ ] Other (please list):
- **i)** [ ] Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? (●) Yes ( ) No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? (●) Yes ( ) No

a) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

a) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based The Division of Behavioral Health (DBH) requires providers to use evidence-based programs

and environmental strategies. DBH uses the following definition for evidence-based programs: 1) Inclusion in a federal list or registry of evidence-based interventions, 2) reported (with positive effects) in a peer-reviewed journal and 3) documentation of effectiveness based on that the intervention is based on a theory of change that is documented in a clear logic or concept, is similar in content and structure to interventions that appear in registries and/or the peer-reviewed literature, is supported by documentation that it has been effectively implemented in the past, and multiple times, in a manner attentive to identifying and selecting evidence-based interventions, scientific standards of evidence and with results that show a consistent pattern of credible and positive effects and is reviewed and deemed appropriate by a panel of informed prevention experts that includes well-qualified prevention researchers who are experienced in evaluating prevention interventions similar to those under review, local prevention practitioners, and key community leaders as appropriate (e.g., officials from law enforcement and education sectors or elders within indigenous cultures.

b) Missouri uses the Strategic Prevention Framework model to implement the four guidelines. The process includes: 1) Assessment of the community's needs, 2) Capacity building to mobilize and address the needs of the community, 3) Development of a prevention plan to identify the activities, programs and strategies necessary to address the needs, 4) Implementation of the prevention plan, and 5) Evaluation of the results to achieve sustainability and cultural competence.

c) Missouri identified appropriate strategies based on validated research, empirical evidence of effectiveness, and the use of local, state, and federal key community prevention leaders such as National Prevention Network, Prevention Technology Transfer Center Network and SAMHSA's Center for Substance Abuse Prevention.

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8. Does your state integrate the National CLAS Standards into the planning step? ( ) Yes (●) No

a) If yes, please explain in the box below.

N/A

b) If no, please explain in the box below.

At this time we do not. Discussions will be held about adding this to next fiscal year's work plan template to monitor the implementation of CLAS standard with prevention providers.

9. Does your state integrate sustainability into the planning step? (●) Yes ( ) No

a) If yes, please explain in the box below.

Sustainability is a part of the goal for each step.

b) If no, please explain in the box below.

N/A

Narratve Question

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Implementation

1. States distribute SUPTRS BG primary prevention funds in a variety of different ways. Please check all that apply to your state:

- **a)** ☐ SSA staff directly implements primary prevention programs and strategies.
- **b)** ☑ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
- **c)** ☐ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
- **d)** ☑ The SSA funds regional entities that provide training and technical assistance.
- **e)** ☑ The SSA funds regional entities to provide prevention services.
- **f)** ☐ The SSA funds county, city, or tribal governments to provide prevention services.
- **g)** ☐ The SSA funds community coalitions to provide prevention services.
- **h)** ☐ The SSA funds individual programs that are not part of a larger community effort.
- **i)** ☐ The SSA directly funds other state agency prevention programs.
- **j)** ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SUPTRS BG primary prevention dollars in at least one of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

Prevention providers disseminate ATOD information within their communities. Partners in Prevention disseminates ATOD information to the 25 college campuses statewide with which they work. Examples include fact sheets on prescription drug misuse, information on drug trends, media campaigns, and county level data fact sheets.

b) Education:

Prevention providers work with school districts in their area to provide evidence-based programming that is specific to their needs such as the Too Good for Drugs, PeaceBuilders, and Second Step curriculum. After school programming for high-risk youth, mentoring programs, and opioid-specific education is offered.

c) Alternatives:

Prevention providers work with their local communities and coalitions to provide alternative drug free activities such as family dances, lock-ins, and events around prom and graduation.

d) Problem Identification and Referral:

The school-based providers provide referral and assessment services as needed. The statewide prevention provider that works specifically with the deaf and hard of hearing population makes referrals to treatment centers as needed; however, this provider has multiple funding sources and referrals to treatment centers are not with SUPTRS BG funds.

e) Community-Based Processes:

All prevention providers collaborate with other agencies and coalitions in their communities to provide effective programming that meets their needs. Prevention providers and local coalitions collaborate to conduct Town Hall meetings on topics such as underage drinking, prescription drug misuse, and Heroin. Prevention providers assist coalitions with developing and distributing their information in ways of direct mailings, brochures, info packets, websites, coalition advertising and marketing.

f) Environmental:

Prevention providers work with their local communities, coalitions and elected officials to work on city/county ordinances, school district policies and state policies. Efforts have included creating city ordinances that increased the age to purchase tobacco products to 21. The prevention providers that receive funding from the block grant provide technical assistance and education to their local communities and coalitions, building their capacity to help make change in their communities. The local coalitions work on city/county ordinances, school district policies and state policies without funding from the Department of Mental Health and without funding from the SUPTRS BG. Only advocacy efforts are funded through the SUPTRS BG.

3. Does your state have a process in place to ensure that SUPTRS BG dollars are used only to fund primary prevention services not funded through other means? (●) Yes ( ) No

a) If yes, please describe.

All prevention providers submit an annual Strategic Work plan, year-end report, and a budget at the beginning and end of the state fiscal year. They also submit a monthly report to DBH detailing the services provided that month. Annual reviews are conducted on all prevention providers to make sure they are in compliance with contract requirements.

4. Does your state integrate National CLAS Standards into the implementation step? (●) Yes ( ) No

a) If yes, please describe in the box below.

Prevention efforts targeting Opioid use among African Americans is being done at Historically Black Colleges and University's such as Lincoln University and Harris Stowe University. Evidence-based curriculum, including, after school programming and mentoring programs are being implemented to target African American youth and high-risk youth in geographically and economically depressed areas.

b) If no, please explain in the box below.

n/a

5. Does your state integrate sustainability into the implementation step? (●) Yes ( ) No

a) If yes, please describe in the box below.

The primary issue with sustaining programming is that there is a large amount of need across the sectors of the state and a smaller amount of funding available. The competing priorities mean that it can be a struggle to sustain programming without additional funding. In order to increase the access to federal funds for our local communities, we have used the Coronavirus Response and Relief Supplement Appropriations Act, 2021 and the American Rescue Plan Act, 2021 funds to implement $100,000 a year for 2 year grants to coalitions who are doing well but not quite ready to apply for DFC or other federal funds. These closely monitored mega grants help the coalitions build capacity and pilot evidence based programming to set them up for successfully applying to larger federal funds. With these funds, we were able to provide funding to 18 coalitions. Each coalition is required to apply for a DFC grant in Year 2 of their funding."

b) If no, please explain in the box below

n/a

Narratve Question

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Evaluation

1. Does your state have an evaluation plan for substance use primary prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan.

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- **a)** [x] Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- **b)** [x] Includes evaluation information from sub-recipients
- **c)** [x] Includes SAMHSA National Outcome Measurement (NOMs) requirements
- **d)** [x] Establishes a process for providing timely evaluation information to stakeholders
- **e)** [x] Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- **f)** [ ] Other (please list:)
- **g)** [ ] Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SUPTRS BG funded prevention services:

- **a)** [x] Numbers served
- **b)** [x] Implementation fidelity
- **c)** [x] Participant satisfaction
- **d)** [x] Number of evidence based programs/practices/policies implemented
- **e)** [x] Attendance
- **f)** [x] Demographic information
- **g)** [ ] Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SUPTRS BG funded prevention services:

- **a)** [x] 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** [ ] Heavy use

- **c)** ☑ Binge use
- **d)** ☑ Perception of harm
- **e)** ☑ Disapproval of use
- **f)** ☑ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- **g)** ☐ Other (please describe):

5. Does your state integrate the National CLAS Standards into the evaluation step? ◉ Yes ○ No

a) If yes, please explain in the box below.

Data is monitored through the Missouri Student Survey. In addition, our Status Report highlights trends in mental illness and the use of alcohol, tobacco and illicit drugs as measured by national and Missouri surveys while the Missouri Epidemiological Profiles track data on what LGBTQ+ data we have plus data for those who serve in the military and by race and gender. Our data querying website also provides data to the public by subpopulation, including race and gender.

b) If no, please explain in the box below.

n/a

6. Does your state integrate sustainability into the evaluation step? ◉ Yes ○ No

a) If yes, please describe in the box below.

Sustainability is a part of the goal for each step.

b) If no, please explain in the box below.

n/a

Footnotes:

STRATEGIC PLAN FOR PREVENTION

2020-2025

DEPARTMENT OF MENTAL HEALTH * DIVISION OF BEHAVIORAL HEALTH

The Missouri Division of Behavioral Health manages programs and services for people who need help for a mental illness or alcohol or drug problem. Services available are prevention, education, evaluation, intervention, treatment, and rehabilitation.
The Division of Alcohol and Drug Abuse (ADA) was created in 1975 and established in statute in 1980 (RSMo 631.010) as part of the Department of Mental Health. In spring 2013, the Divisions of Comprehensive Psychiatric Services and Alcohol and Drug Abuse merged into one division, the Division of Behavioral Health (DBH).

DBH Prevention Priorities

The Division's prevention program covers all segments of the population at potential risk for drug and alcohol use. However, the primary focus is on children who have not yet begun use. Research finds that brain changes caused by drinking before age 15 could predispose adolescents to a lifetime of alcohol dependency. Children are drinking earlier and at more dangerous levels than they did many years ago.

Prevention Goals

Create positive community norms, policy change, reduced alcohol, tobacco and other drug availability, and increased enforcement at the state and community level through the implementation of effective, evidence-based prevention programs and environmental strategies to prevent and reduce substance use and its consequences for youth, adults and families in Missouri.

Prevention Objectives

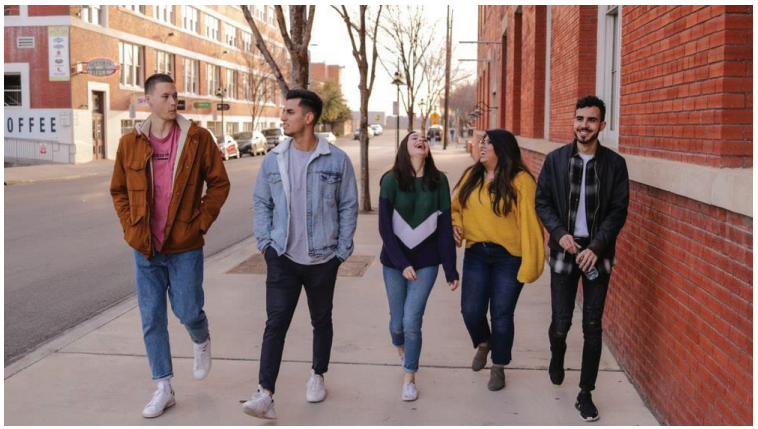
- By FY 2025, consequences of substance use in Missouri will be reduced as a result of prevention programs implementing effective and evidenced-based programs and strategies and the Strategic Prevention Framework.
  - Reduce alcohol, tobacco and marijuana use among youth.
  - Reduce alcohol and drug use, including opioid misuse, among general population.
  - Reduce unnecessary accidents and emergency room visits.

Prevention Outcomes

- Reduced accidents and emergency room visits and hospitalization as a result of alcohol consumption by youth and adults.
- Reduced accidents and emergency room visits and hospitalization related to marijuana and other drugs by Missouri's youth and adults.

Programs and Numbers Served

Contracted Prevention Providers	Number of Programs	Numbers Served
Prevention Resource Centers	11	346,767
Direct Programs/Services	7	6,274
School-Based Programs (Schools served)	38	10,400
College-Based Program/Services	1	190,425
Deaf & Hearing Impaired Services	1	6,078
Partnerships for Success	5	72,541



DBH Prevention Targets

Binge Drinking: By FY 2025, reduce binge drinking among Missouri's youth and young adults from FY 2018 baselines.

- The percentage of Missourians age 12 to 20 who engaged in binge alcohol use in the past month was higher than that for the United States (13.33% vs. 11.24%) (NSDUH, 2018-2019).
- Students who binge drink are at increased risk of being assaulted (including sexually) or injured, or experiencing academic and legal problems (U.S. Department of Health and Human Services, 2007).

Current Use of Alcohol: By FY 2025, reduce use of alcohol among youth in past 30 days from FY 2018 baselines.

- Missouri's youth ages 12 to 17 are drinking at rates similar to that of the nation as a whole (NSDUH, 2018-2019).
- Research indicates that individuals who start drinking early in life are at increased risk to develop alcohol addiction and to incur alcohol-related injuries later in life (Hingson et al, 2000; Hingson et al, 2006).
- In a given year, about 7,600 Missourians receive treatment for alcohol use disorders through the Missouri Division of Behavioral Health. (Smith et al, 2020).
- In 2020, approximately 34,000 hospital and emergency room admissions across the state were alcohol-related (Smith et al, 2020).

Current Use of Marijuana: By FY 2025, maintain or reduce use of marijuana among youth in past 30 days from FY 2018 baselines.

- While current rates of marijuana use is lower than the national average across all age groups (NSDUH, 2018-2019), medical marijuana was legalized in Missouri in 2018. The state's first dispensary opened in October 2020 in St. Louis. This increased availability raises concerns for increased use in Missouri youth.
- In a given year, about 4,200 Missourians receive treatment for marijuana use disorders through the Missouri Division of Behavioral Health. (Smith et al, 2020).

Substance Use Onset: By FY 2025, delay onset of first use of alcohol and marijuana among youth from FY 2018 baselines.

- Among Missouri students who have ever used alcohol, the average age of first use is 13.4. The average age of first use of marijuana is 14.3 (Missouri Student Survey, 2020).

Youth Use of Tobacco: By FY 2025, reduce smoking and other tobacco use among Missouri's youth from FY 2018 baselines.

- Missouri's youth ages 12 to 17 are smoking at a higher rate than compared to that of the nation (3.41% in the past month vs. 2.50%) (NSDUH, 2018-2019).
- More Missouri youth use e-cigarettes / vapes than standard cigarettes (past month use 21.1%) (Missouri Student Survey, 2020).
- An estimated 9,768 Missourians die each year from smoking (Smith et al, 2020).
- Smoking has been implicated in a number of diseases including various cancers, respiratory diseases, fertility and pregnancy complications, cataracts, hip fractures, low bone density, and peptic ulcer disease (U.S. Department of Health and Human Services, 2004).

Youth Access to Tobacco: Continue to meet the requirements of the Synar Amendment for reducing the sale and distribution of tobacco products to individuals under the age of 18.

- The federal Synar regulation requires all states to reduce the number of successful illegal purchases by minors to no more than 20 percent of attempts in each state per year.
- Missouri has reduced the percentage of its retailers failing tobacco checks from 40 percent in 1996 to 7.5 percent in 2020 – as measured by the state's annual Synar survey.

Current Misuse of Prescription Drugs / Opioids: By FY 2025, reduce prescription misuse (with a focus on opioids) among Missouri's youth from FY 2018 baselines.

- Statewide, all drug overdose deaths increased approximately 17% in 2020 compared to 2019. Opioid-involved drug overdose deaths represent the majority (73%) of total drug overdose deaths in Missouri. (MO Department of Health and Senior Services, 2020)
- Missouri's youth ages 12 to 17 and adults 18+ are misusing pain relievers a higher rate than compared to that of the nation (2.74% in the past year vs. 2.53% and 3.80% in the past year vs. 3.69%) (NSDUH, 2018-2019).

Risk Awareness: By FY 2025, increase the number of youth who perceive risk/harm of alcohol, cigarettes and marijuana from FY 2018 baselines.

- A significant number of Missouri youth believe that there is *only a slight risk at most* if they engage in binge drinking (24.1%), smoking a pack of cigarettes per day (18.9%), using e-cigarettes (33.2%) or smoking marijuana (39.2%) (Missouri Student Survey, 2020).
- The percentage of Missourians 18+ who believe binge drinking (39.85% vs. 45.00%), smoking cigarettes (66.16% vs. 72.15%) and smoking marijuana (20.22% vs. 24.56%) is a "great risk" is lower than the national average (NSDUH, 2018-2019).

Current Use of Methamphetamine: By FY 2025, reduce methamphetamine use among Missouri's adults from FY 2018 baselines.

- Missouri adults 18+ are using methamphetamine at a higher rate than the national average (.94% vs .76%) (NSDUH, 2018-2019).
- In a given year, about 7,500 Missourians receive treatment for methamphetamine use disorders through the Missouri Division of Behavioral Health. (Smith et al, 2020).

Missouri Prevention NOMs

Prevention NOMs	Ages 12-17			Ages 18+		
	Year 1	Year 2	Year 2-1 Variance	Year 1	Year 2	Year 2-1 Variance
30-day Use						
Alcohol+	10.8%	9.2%	-1.6%	55.0%	53.6%	-1.4%
Cigarettes+	5.2%	3.4%	-1.8%	23.0%	21.4%	-1.6%
Other Tobacco Products+	7.3%	5.1%	-2.2%	29.1%	26.1%	-3.0%
Pain Relievers+	3.5%	2.7%	-0.8%	4.4%	3.8%	-0.6%
Marijuana+	5.8%	5.9%	0.1%	8.7%	9.3%	0.6%
Illegal Drugs Other than Marijuana+	8.3%	7.5%	-0.8%	10.6%	10.9%	0.3%
Perception of Risk						
Alcohol (no dosage given)*	60.21%	53.55%	-6.66%			
Cigarettes (1+ pack per day)*	83.05%	81.09%	-1.96%			
E-Cigarettes / Vapes (no dosage given)*	58.20%	66.80%	8.60%			
Marijuana (no dosage given)*	63.07%	60.76%	-2.31%			
Prescription Drug Misuse*	87.02%	85.79%	-1.23%			
Binge Drinking Once or Twice a Week+				40.7%	39.9%	-0.9%
Smoking Marijuana Once a Month+				24.5%	20.2%	-4.3%
Smoking One or More Packs of Cigarettes Per Day+				67.5%	66.2%	-1.3%
Age of First Use						
Alcohol*	12.90	13.36	0.46			
Cigarettes*	12.68	13.23	0.55			
Marijuana*	14.18	14.31	0.13			
Prescription Drug Misuse*	11.63	11.20	-0.43			
Disapproval of Youth Use						
Alcohol*	67.6%	67.0%	-0.6%			
Cigarettes*	87.1%	87.7%	0.6%			
E-Cigarettes / Vapes*	76.9%	77.1%	0.2%			
Marijuana*	79.2%	75.0%	-4.2%			
Prescription Drugs*	94.8%	94.5%	-0.3%			

**Missouri Student Survey, Year 1 = 2018, Year 2 = 2020*

+NSDUH, Year 1 = 2016-2017, Year 2 = 2018-2019

Green highlight indicates change in the desired direction

Prevention Strategies and Activities

The Division of Behavioral Health contracts with various prevention agencies across the state to plan and implement prevention strategies and programs. The state's investment in the infrastructure of the Substance Use Prevention Network, Prevention Resource Centers (PRC), and the Partners in Prevention program on state college campuses, positions Missouri to achieve population-level changes in substance use patterns locally and across the state. The Prevention Resource Centers scope of work incorporates the Strategic Prevention Framework as well as many other specific elements to promote positive prevention outcomes.

These funded programs are required to:

- Develop, implement and evaluate a comprehensive strategic plan with identified target outcomes based on community needs.
- Utilize data to identify prevention needs, gaps, and resources.
- Implement evidence-based programs and strategies that address identified gaps and needs. Implement strategies with fidelity.
- Implement the Strategic Prevention Framework.
- Evaluate services and progress toward outcomes.
- Have formal agreements with multiple community-level partners to collaborate in community planning and implementation.
- Select and implement prevention practices that are culturally appropriate.
- Select a comprehensive package of evidence-based strategies that are likely to have a positive impact on the community. The selected strategies should address one or more of the Center for Substance Abuse Prevention's six core strategies.
- Address sustainability.
- Report NOMs data and other information to DBH in a timely manner.
- Participate in public policy and advocacy support and training.
- Promote a unified prevention message across the state and collaborate on media campaigns.
- Implement tobacco merchant education to retailers (PRCs).
- Be a DBH certified program, which means each funded program must be in compliance with the Core Rules for Psychiatric and Substance Abuse Programs, General Program Procedures, and the Certification Standards for Alcohol and Drug Abuse programs.

Funded program staff are required to:

- Meet DBH Certification Standards for Personnel.
- Acquire and maintain the Missouri Prevention Specialist (MPS) credential.
- Participate in Substance Abuse Prevention Specialist Training (SAPST).

- Use data to identify local needs and develop strategic plans.
- Assess effectiveness of prevention strategies.
- Conduct evaluation and monitor progress toward goals.
- Plan for workforce development.

Other Strategies and Activities

- **Show Me Zero Suicide Initiative Grant**
  Aims to reduce youth suicide through an integrated systems-level approach, which includes establishing a continuity of care model for youth at risk of suicide and promoting the adoption of suicide prevention as a core priority of youth-serving institutions, such as hospitals and schools. Through collaboration with these organizations, this initiative is effectively identifying youth ages 10-24 who are at risk for suicide and providing them immediate linkage to intensive services and follow-up care.

  Services are being focused on a five-county region in western Missouri, centered on Jackson County, which includes Kansas City, as well as surrounding counties with more rural areas.
  The overall aim of the *Show Me Zero Youth Suicide Initiative* is to reduce suicides and suicide attempts by accomplishing three major goals:
  1) Improve the system of care of suicidal youth who use hospital emergency departments, in-patient psychiatric facilities, and/or crisis hotlines.
  2) Improve the capacity of school systems to identify, respond, and refer youth at risk of suicide.
  3) Strengthen overall prevention efforts for at-risk youth populations in other settings.

- **Signs of Suicide (SOS) Training**
  DMH contracted Prevention Resource Center (PRC) staff have been trained as SOS Trainers. The PRC's provide this training to school staff across the state.

- **Zero Suicide Initiative**
  The Coalition for Community Behavioral Healthcare, in collaboration with DMH and the national Suicide Prevention Resource Center, has hosted a Show Me Zero Suicide Learning Collaborative for Community Mental Health Centers the last two years with another one planned next year. DMH facilities are also being educated on the Zero Suicide framework.

- **Partnerships for Success Grant**

  In 2020, DMH was awarded a five-year Partnerships for Success grant to target substance use among youth ages 12 to 18 and methamphetamine use in adults in 81 counties in Missouri. A resiliency approach is being used to reduce risk factors and promote protective factors common to alcohol,tobacco, and other drug use, including prescription drug misuse. Missouri's program is designed to 1) enhance protective factorsand reverse or reduce risk factors, 2) address all forms of substance use, 3) enhance substance use workforce skills, and 4) present consistent, community-wide messaging. Interventions target the individual, family, and community ecological levels tosupport positive youth development and are based upon the Strategic Prevention Framework.

- **Missouri Heroin Overdose Prevention and Education (MO HOPE) Project**

  In 2016, DMH was awarded a 5-year federal grant to directly address the opioid crisis through overdose education and naloxone distribution. Priority area is the Eastern Region.

- **State Opioid Response Grant**

  DMH was awarded a federal grant to improve access to evidence-based practices in prevention, treatmentand recovery specific to opioid misuse.

  Prevention initiatives include:

  - Overdose education and naloxone distribution
  - ECHO expert panelists will educate providers about the treatment of chronic pain.
  - Generation Rx program will be implemented in schools in St. Louis and Springfield to educate on medication safety, etc.
  - Mentoring and wraparound services will be provided through Big Brothers Big Sisters of Eastern MO for particularly African American males ages 5-25 that reside in North St. Louis City, St. Louis County, Cape Girardeau County, and Scott County.

- **Mental Health First Aid (MHFA)**

  DMH contracted Prevention Resource Center (PRC) staff have been trained as Adult and Youth MHFA Trainers. The PRC's provide this training across the state.

Implementation Plan

All DBH contracts for prevention services are in place for one year, from July 1st until June 30th the following year. Contracts are monitored on a monthly basis by state-level prevention staff. Contracts are renewed annually based on availability of funding, fulfillment of contract terms, and effectiveness of services.

Prevention Resource Centers are required to submit a Strategic Work Plan to DBH annually for approval. Once approved, these plans are monitored by DBH staff to ensure progress toward identified goals.

Efforts through Block Grant funding and the 2020 Partnerships for Success grant are being made to increase training for the Prevention Resource Centers and fill gaps as determined by the bi-annual Workforce Development Survey.

The Statewide Epidemiology Workgroup will assist the state in making the link between the data they generate and the prevention objectives outlined, as well as providing local programs with data that drives the selection of their program strategies that will also address the statewide targets.

Prevention Infrastructure Goals

- DBH will ensure that prevention services are part of a recovery-oriented system of care.
- DBH will ensure that treatment and prevention services are linked with broader healthcare and social service systems.
- DBH will continue working with the prevention resource centers and coalitions to broaden their scope of work to include preventing mental, emotional, and behavioral disorders, as many of the risk and protective factors overlap, and continue linking them withpotential opportunities.

DBH will continue to require contracted prevention providers to submit demographic data to DBH monthly. The data collected is used to complete the Prevention sections of the Substance Abuse and Mental Health Services Administration Substance Abuse Prevention and Treatment Block Grant application, special requests from National Association of State Alcohol and Drug Abuse Directors, Data Consolidated Coordinating Center, Center for Substance Abuse Prevention, and for state-level reporting.

Workforce Development

Missouri has made significant steps in preparing the substance use prevention workforce by establishing a credentialing process. The Division of Behavioral Health and the Missouri Credentialing Board (MCB) worked together to establish a three-tiered credentialing process to reach the entire spectrum of prevention professionals. All three levels of credentialing are marked by training, experience and education. Missouri has over 160 prevention professionals with a credential. The Division of Behavioral Health requires that all funded prevention programs obtain at least the first credential level. MCB coordinate trainings across the state to assist individuals in acquiring the skills and experience needed to move across credentialing levels. More information about the three credential levels can be found at www.missouricb.com.

Prevention workforce characteristics have significant implications for prevention programming. The strategic prevention framework is a rigorous model that requires an understanding of prevention science and the ability to perform numerous capacity building, program management, and evaluation activities. To ensure the workforce is adequately trained, the first Workforce Development Survey was administered in 2019. DBH has begun providing trainings to address gaps uncovered by the survey and will assess these efforts by repeating the survey in 2021.

Evaluation Plan

The move to science-based prevention called for sound approaches to needs assessment, resource allocation, program monitoring and improvement, and documentation of prevention outcomes. Evaluation activities are integral to program management and to the Strategic Prevention Framework. Evaluation efforts should provide support for the planning, implementation and improvement of prevention efforts in Missouri. At the beginning of the programming process, needs must be assessed and programs and strategies must be identified to address needs. Once programs have been implemented, evaluation efforts can serve to assess the degree to which prevention efforts have been successfully implemented.

Local Level:

- Prevention Resource Centers (PRCs) annually conduct a community needs assessment to assist in developing their strategic work plans. PRCs evaluate their programs for effectiveness.

State Level:

- Assure Data is available to communities by monitoring state and local drug trends:
  - Missouri Student Survey and Report
  - ADA Status Report
  - Missouri Data Querying Site
- DBH contracted prevention providers will submit demographic data to DBH.
- DBH monitors local prevention providers for quality of service delivery and fidelity.
- DBH and Discretionary Grants provide training on evaluation skills and techniques.

The Division of Behavioral Health will provide data analysis in support of a Prevention Needs Assessment. DBH will continue to annually publish the *Status Report on Missouri's Alcohol and Drug Misuse Problems*. This report is updated annually and issued online by DMH. The purpose of this document is to support research, education, policy-making, planning, and evaluation activities. As a reference tool, the report provides consistent sets of year-to-year data on alcohol and drug usage rates and reported events that result from substance use. In addition, DBH has developed an online reporting website for the Missouri Student Survey, a biannual consumption and risk and protective factor survey of students ages 12-17. This will allow all communities in Missouri to locate and run basic analyses on the data, drilling down to the local level.

The State Epidemiology Workgroup (SEW) will assess data trends and geographical variations to develop an assessment of prevention need in the state and prepare an annual summary report prioritizing areas of need. The work by the SEW will help coalitions conduct needs assessments, planning, and subsequent evaluations. The SEW will continue to monitor drug trends across the state. The SEW will assist the state in making the link between the data that they generate and the prevention objectives outlined, as well as providing local programs data that drive selection of local program strategies that will also address the statewide targets.

The Division of Behavioral Health has a longstanding partnership with the Missouri Institute of Mental Health who is dedicated to providing research, evaluation, policy and training expertise to the Department and other organizations.

Synar

DBH will continue to ensure that Missouri stays in compliance with the Synar Amendment and will maintain a retailer violation rate lower than 20%. Contracted PRCs will continue to provide merchant education to tobacco retailers across the state. DBH will continue to collaborate with the Division of Alcohol and Tobacco Control (ATC) on enforcement and training efforts.

% of MO Retailers Failing Tobacco Checks		Meet Synar?
2020	7.5%	yes
2019	7.8%	yes
2018	6.3%	yes
2017	13%	yes
2016	7.7%	yes
2015	11.3%	yes
2014	7.2%	yes
2013	7.4%	yes
2012	10.4%	yes
2011	10.2%	yes
2010	10.6%	yes
Baseline 1996	40.30%	N/A

Calendar year is provided.

Sustainability

DBH ensures that activities are sustainable by training funded programs and coalitions in approaches that promote sustainability at every step of the Strategic Prevention Framework. Funded programs will be expected to build sustainability into their data collection process, plan and approach by building community readiness; seeking buy-in from community leaders; using evidence-based approaches that are monitored and evaluated; leveraging funds whenever possible; and collaborating with local prevention partners. Centralizing prevention data is also an essential component of sustainment. A good beginning was made with the SEW and the Strategic Prevention Framework State Incentive Grant. The DBH Status Report, DHSS's MICA system and the Missouri Student Survey are ongoing data resources for agencies and communities. Also, DBH has developed a data querying site that is available to the public.

DBH will continue to develop Missouri's prevention workforce. DBH will also continue to offer workforce development opportunities.

DBH will continue to partner with other state agencies/groups providing prevention services across the state to leverage funds and opportunities whenever possible. These agencies include but are not limited to: the Department of Health and Senior Services, Department of Elementary and Secondary Education, Division of Highway Safety, and Department of Public Safety.

DBH will continue working with the PRCs and community coalitions to broaden their scope of work to include preventing mental, emotional, and behavioral disorders, as many of the risk and protective factors overlap, and continue linking them with potential opportunities.

Cultural Competence

Through current projects DBH continues to develop the understanding needed to guide the identification and implementation of culturally, competent, evidence-based programs and strategies following the assessment of risk and protective factors, readiness, assets and resources, and priorities. Staff and funded program staff should be familiar with local communities' cultures and languages, and also have additional cultural skills and knowledge that lend them to working with any new emerging cultural situations which may present them. Training is provided to staff and funded program staff as needed.

The State Advisory Council for the Division of Behavioral Health will continue to contribute to the process of identifying culturally responsive, evidence-based programs and strategies. Also, DBH and MIMH have extensive experience implementing and evaluating culturally appropriate/competent prevention interventions. DBH will conduct annual assessments of the prevention system to ensure that programs, policies, and services are offered in ways that are meaningful to recipients consistent with their cultural world views. DBH will continue to devise strategies that enhance and guarantee cultural competence throughout the system.

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Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

The Department of Mental Health (DMH), Division of Behavioral Health (DBH) supports and expects a variety of basic and evidence-based services within the mental health service system for individuals with serious mental illness and children/youth with serious emotional disturbance. Basic and evidence-based services include community support services, peer and family support services, medication services, school-based services, disease management, and Behavioral Health Homes in order to assist individuals in managing their mental and physical health conditions while being supported to live in the community. Evidence based practices are supported and encouraged, such as Assertive Community Treatment (ACT), Integrated Treatment for Co-occurring Disorders (ITCD), and supported employment, which are shown to increase outcomes for individuals receiving evidence-based services. The DBH expects providers to have an array of housing options and intensive services in order to keep individuals in the housing of their choice.

Treatment Family Home – A "home-like" setting in which intensive therapeutic mental health interventions are provided. A maximum of three children and youth may receive services in a TFH. Treatment Family Home (TFH) -Based Services are designed for children and youth whose therapeutic needs cannot be met in their natural home or an alternative therapeutic environment is required for transition back to their home or least restrictive setting. Intensive therapeutic interventions are provided to improve the children and youth's functioning and to prevent them from being removed from their natural home and placed into a more restrictive residential treatment setting. Each child and youth will have an individual treatment plan developed collaboratively with the family, child, natural supports, agencies and community partners. A maximum of three children may receive services in a TFH.

Professional Parent Home – "home-like" setting that provides intensive therapeutic mental health interventions for a child. Only one child and/or youth is placed in a Professional Parent Home (PPH). PPH-Based Services are designed for children and youth whose therapeutic needs cannot be met in their natural home or an alternative therapeutic environment is required for transition back to their home or least restrictive setting. Intensive therapeutic interventions are provided to improve the child's functioning and to prevent them from being removed from their natural home and placed into a more restrictive residential treatment setting. Each child or youth will have an individual treatment plan developed collaboratively with the family, child/youth, natural supports, agencies and community partners.

Intensive Evidence Based Practice – This service includes implementation of supports for treatments that have been proven demonstrably effective for children and youth. The evidence-based practice is based on the individual's needs and desired outcomes as identified on the treatment plan.

Psychosocial Rehabilitation – A combination of goal-oriented and rehabilitative services provided in a group setting to improve or maintain the individual's ability to function as independently as possible with their family or community.

Day Treatment – This service offers an alternative form of care to children and youth who have serious emotional disturbance and who require a level of care greater than can be provided by the school or family, but not as intensive as inpatient service. Day Treatment is an intensive array of services provided in a structured, supervised environment designed to reduce symptoms of psychiatric disorder and maximize the individual's functioning so they can attend school and interact in their community and family setting.

Family Assistance – These services are provided for the child and/or family. Activities provided in the delivery of services may include home living and community skills, communication and socialization, leisure activities for the child, arranging for appropriate services and resources available in the community.

Peer Support Services – Peer support services are delivered by individuals who have been successful in recovery from mental and/or substance use disorders who help others experiencing similar situations. Through shared understanding, respect, and mutual empowerment, peer support services help people become and stay engaged in the recovery process and reduce the

likelihood of relapse. Peer support services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustained recovery process.

Family Support – Services are provided for a family member of a child or youth who had or currently has a behavioral or emotional disturbance disorder and may involve a variety of related activities to the development or enhancement of the services delivery system.

Youth Peer Support – Support services provided by certified Youth Peer Specialist to individuals ages 13 to 25 to support, encourage, and model positive self-advocacy, recovery and resiliency.

Community Support – Services are designed to coordinate and provide services and resources to individuals and their families as necessary to promote resilience.

Targeted Case Management – This service includes arrangement, coordination and participation in the assessment to ensure that all areas of the individual's and family's life are assessed to determine unique strength and needs.

Respite – Temporary care provided by trained, qualified personnel, on a time-limited basis, for the purpose of meeting family needs and providing mental health stabilization.

Wraparound – Providing direct and indirect service to assist in maintaining the child or youth in regular home, school and/or community placement to ensure the functional success of the child or youth in the community. Types of services may include basic needs supports, transportation supports, social-recreational supports, clinical/medical supports and other supports.

Assertive Community Treatment (ACT) – Provision of multiple types of services to adults with serious mental illness and transitional age youth (TAY) with serious emotional disturbance which are received within their own home 24 hours per day, 7 days a week. Services provided to TAY are round-the-clock staffing of psychiatric unity, but within the comfort of their own home and community.

Integrated Treatment for Co-occurring Disorders (ITCD) – Evidence-based model of treatment for people with serious mental illnesses and co-occurring substance use disorders where combined treatment is received for mental illness and substance use disorders.

Intensive Home-based Services for Adults and Transitional Aged Youth – Medically necessary services/supports are provided to adults who have a serious mental illness and are transitioning from an inpatient psychiatric hospital to the community, or who are at risk of returning to inpatient care due to their clinical status or need for increased support. Services and supports are provided in the individual's natural home. The home/program is structured to meet individual needs to ensure safety and prevent the individual's return to a more restrictive setting for services. Settings can include intensive residential treatment, psychiatric individualized supported living and/or clustered apartments.

Inpatient Diversion – A full array of intensive clinical services, delivered in a highly supervised, 24-hour structured therapeutic environment. This service is designed to avoid the need for hospitalization while working to restore an individual to a higher level of functioning, decrease risk of harm, and prepare for transition to a less restrictive setting.

Housing Supports – Housing is a critical component for recovery and wellness. The DMH coordinates both state and federal funds to provide direct rental assistance to individuals and families with mental illness, substance use disorders, developmental disabilities, and HIV/AIDS who are homeless or experiencing housing crisis. The DMH believes that housing is key to helping Missourians with disabilities and their families attain self-determination and independent living. A full array of housing options are available from residential care facilities to independent apartments. Funding for housing comes from HUD, Adult Community Residential General Revenue Allocation, and special projects funding.

Intensive Community Psychiatric Rehabilitation Residential (ICPR RES) – ICPR RES is comprised of medically necessary on-site services for adults who have been unsuccessful in multiple community settings and/or present an ongoing risk of harm to self or others.

In addition, the state supports diversionary programs that help individuals who are not currently engaged in services, but who access the health/hospital systems frequently such as Missouri's Behavioral Health Homes (HCH) initiative. The HCH initiative enhances the existing psychiatric rehabilitation program by adding Nurse Care Managers (NCM) and a Specialized Healthcare Consults (SHC) to each Community Mental Health Center (CMHC) or Certified Community Behavioral Health Organization (CCBHO). Enhancing the psychiatric rehabilitation teams with a NCM and SHC, provides the access to a wealth of care management reports designed to help them both identify treatment gaps and to assist individuals in developing healthy lifestyles and managing their chronic illnesses. The Disease Management Programs currently in place are the result of collaboration between the DBH and the state Medicaid agency, MO HealthNet (MHD). The DM 3700 Project started in November 2010 and identifies Medicaid- enrolled adults with a serious mental illness and high medical costs who were currently not engaged in treatment at a CMHC or CCBHO. The SUD DM Project was implemented in 2014 through a partnership with MHD and DBH. SUD DM identifies Medicaid-enrolled adults with substance use disorders and high medical costs who were not currently engaged in treatment. DBH funds outreach efforts and the state Medicaid agency funds behavioral health treatment. Emergency Room Enhancement (ERE) was designed to prevent unnecessary hospital admissions and/or extended psychiatric hospitalizations for adults and youth. The program is

intended to increase behavioral health care access for individuals who use the emergency room seeking treatment for psychiatric conditions and/or substance use disorders. Each ERE region has partnered with local hospitals, community health centers, law enforcement agencies, substance use treatment facilities, and social service providers to coordinate care for the whole individual by addressing behavioral, physical and basic needs.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a)	Physical Health	(•) Yes ( ) No
b)	Mental Health	(•) Yes ( ) No
c)	Rehabilitation services	(•) Yes ( ) No
d)	Employment services	(•) Yes ( ) No
e)	Housing services	(•) Yes ( ) No
f)	Educational Services	(•) Yes ( ) No
g)	Substance misuse prevention and SUD treatment services	(•) Yes ( ) No
h)	Medical and dental services	(•) Yes ( ) No
i)	Support services	(•) Yes ( ) No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	(•) Yes ( ) No
k)	Services for persons with co-occuring M/SUDs	(•) Yes ( ) No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

3. Describe your state's case management services

Case management services are the arrangement and coordination of an individual's treatment and rehabilitation needs. This includes the coordination of other medical, social, and educational services and supports. Case Management also includes the monitoring of services and support activities to assess the implementation of the individualized plan and progress towards outcomes specified in the plan. Individuals are accompanied to services when necessary to achieve desired outcomes or to access services. Direct assistance is provided to the child, youth, family, and/or adult including coaching and modeling of specific behaviors and responses (the direct assistance may not involve individual or family counseling or psychotherapy).

4. Describe activities intended to reduce hospitalizations and hospital stays.

Activities designed to reduce hospitalizations include illness management, crisis prevention, Assertive Community Treatment (ACT) and wellness coaching interventions that are individualized to each individual's situation. Intensive services are wrapped around individuals who have been less successful in community living, such as services provided in the home that assist with daily living and symptom management. Additional activities include the ERE program. ERE primary goals are to prevent repeated Emergency Department visits and hospitalizations as well as to decrease rates of those unhoused, unemployed and those involved with law enforcement.

The 988 Suicide & Crisis Lifeline (988) is a three-digit dialing code for anyone experiencing a mental health, suicide, or substance use crisis. 988 offers rapid access to a trained crisis specialist who will listen, offer support, and connect the individual to services and supports. Missouri has seven centers that provide 24/7 and statewide coverage of all calls, texts, and chats that originate in state. Missouri also has a backup system intended to offer a second opportunity for calls to route to a local crisis center before routing to a national backup center. 988 is the front door to Missouri's behavioral health crisis system of care, which is intended to keep people safe in their communities and prevent the need for a higher level of care, such as hospitalization.

Mobile Crisis Response services offer community-based crisis intervention deployed to wherever a crisis is occurring, including an individual's home, or other location in the community. Mobile crisis response teams provide a consistent and quality response that promotes the best outcomes for anyone in crisis. Statewide and 24/7 mobile crisis response services are intended to divert individuals away from more intensive care, such as hospital and jail settings.

Behavioral Health Crisis Centers (BHCCs) provide intervention and assistance for law enforcement, Community Behavioral Health Liaisons, and hospitals to connect individuals in a behavioral health crisis, possibly preventing the individual from entering the community justice system and diverting them to the community-based treatment most appropriate for their level of need. In FY2022, Missouri dedicated approximately $11 million in state funding to expand BHCCs. There are currently 18 operational BHCCs, and funding has been approved to add four additional locations in FY24.

Please indicate areas of technical assistance needed related to this section.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	6.06%	
2.Children with SED	7%	

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

Statewide prevalence for adults with Serious Mental Illness (SMI) was obtained from the 2021 National Survey on Drug Use and Health (NSDUH) State Prevalence Estimates. Statewide prevalence for children with Serious Emotional Disturbance (SED) are obtained from estimates published in the federal register (FR Doc. 98-19071; FR Doc. 99-15377). Missouri does not have estimates on incidence for SMI or SED.

Please indicate areas of technical assistance needed related to this section.

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs.

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care*?

a)	Social Services	(•) Yes	( ) No
b)	Educational services, including services provided under IDEA	(•) Yes	( ) No
c)	Juvenile justice services	(•) Yes	( ) No
d)	Substance misuse preventiion and SUD treatment services	(•) Yes	( ) No
e)	Health and mental health services	(•) Yes	( ) No
f)	Establishes defined geographic area for the provision of services of such systems	(•) Yes	( ) No

Please indicate areas of technical assistance needed related to this section.

**A system of care is: A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.*
https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

a. Describe your state's targeted services to rural population. **See SAMHSA's Rural Behavioral Health page for program resources**

The State of Missouri is divided into service areas, some of which include rural areas. Behavioral Health Providers established a number of service sites within these service areas in an effort to efficiently and effectively serve individuals in rural areas. Telehealth has also become an important and efficient factor in delivering services to the rural populations. Additionally, staff drive to individual's homes to provide services when individuals are not able to come to service sites. Several Behavioral Health Providers have acquired mobile units to assist with service delivery and meet the needs in the community

b. Describe your state's targeted services to people experiencing homelessness. **See SAMHSA's Homeless Programs and Resources for program resources**

The DBH supports Projects for Assistance in Transition from Homelessness (PATH) programs which supports services to individuals who have mental illness or substance use disorders who are homeless or are at risk of being homeless. Additionally, the DBH provides Shelter Plus Care rental assistance to over 2,000 households monthly. These are Continuum of Care, permanent supportive housing projects that serve literally and chronically homeless households. These projects span 89 of the 114 counties in Missouri. The DBH also provides the Rental Assistance Program which creates and sustains project based rental assistance for homeless individuals in recovery as well as one-time assistance to create housing opportunities for households experiencing housing crisis. Also, data indicates the ERE project has positively impacted the homeless population. Housing Liaisons have been added with the Block Grant Supplemental funding to outreach to people experiencing homelessness and work with the local Continuum of Care. Forty-seven Housing Liaisons were added to the behavioral health provider agencies.

c. Describe your state's targeted services to the older adult population. **See SAMHSA's Resources for Older Adults webpage for resources.**

Older adults are included within our normal service system.

Please indicate areas of technical assistance needed related to this section.

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. A priority topic for SAMHSA is increasing access to treatment for SMI and SUD using telehealth modalities. Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client-provider interactions. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out-of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural or underserved areas. Telehealth can be integrated into an organization's standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access, the SAMHSA Evidence Based Resource Guide, **Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders**.

Criterion 5

a. Describe your state's management systems.

The DMH receives annual State of Missouri allocations to fund provider organizations in the delivery of mental health services. Provider organizations identified as a Certified Community Behavioral Health Organization (CCBHO) and/or a Community Mental Health Center (CMHC) receive allocations to support the uninsured, underinsured as well as Medicaid-insured Missourians. The match dollars for the Medicaid is provided via the State of Missouri for all provider organizations. Provider organizations are encouraged to pursue grant funding and to participate in DMH driven funding opportunities. Behavioral Health Providers are required to staff programs with qualified staff for each service type. Behavioral Health Providers are required to ensure staff receive the necessary trainings to provide the service they are delivering. Trainings are available within organizations and via the Missouri Behavioral Health Council (MBHC) for Behavioral Health Providers that are members of the MBHC. The DBH requires CCBHOs to meet and deliver crisis intervention services to all citizens of Missouri by providing walk-in and mobile crisis services. There are also seven call centers for 988/crisis calls across the state. Some organizations staff hospital emergency rooms with trained mental health professionals to assist in meeting mental health crisis needs of those presenting at hospital emergency rooms. The DBH is working cooperatively with law enforcement to ensure law enforcement are trained in handling mental health emergency and crisis situations. Additionally, the DBH has worked with technical colleges to develop an associate's degree for mental health workers. The DBH also collaborated with the State Medicaid agency to expand the pool of medication service providers due to the shortage of psychiatrists in Missouri. The DBH plans to continue to utilize funding to serve as many individuals as possible that are in need of mental health services and that these individuals be served by a sufficient number of adequately trained staff.

b. Describe your state's current telehealth capabilities, how your state uses telehealth modalities to treat individuals with SMI/SED, and any plans/initiatives to expand its use.

Several grant opportunities supported Behavioral Health Providers in the effort to expand telehealth capacities. The DBH adopted several relaxations to service delivery afforded by the COVID-19 public health emergency. The DBH continues to identify ways to encourage telehealth services, when clinically appropriate, to meet the needs of individuals throughout the state.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SUPTRS BG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i)	Screening	(•) Yes ( ) No
ii)	Education	(•) Yes ( ) No
iii)	Brief Intervention	(•) Yes ( ) No
iv)	Assessment	(•) Yes ( ) No
v)	Detox (inpatient/residential)	(•) Yes ( ) No
vi)	Outpatient	(•) Yes ( ) No
vii)	Intensive Outpatient	(•) Yes ( ) No
viii)	Inpatient/Residential	(•) Yes ( ) No
ix)	Aftercare; Recovery support	(•) Yes ( ) No

b) Services for special populations:

i)	Prioritized services for veterans?	(•) Yes ( ) No
ii)	Adolescents?	(•) Yes ( ) No
iii)	Older Adults?	(•) Yes ( ) No

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? (●) Yes ( ) No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? (●) Yes ( ) No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? (●) Yes ( ) No

4. Does your state have an arrangement for ensuring the provision of required supportive services? (●) Yes ( ) No

5 Has your state identified a need for any of the following:

a) Open assessment and intake scheduling ( ) Yes (●) No

b) Establishment of an electronic system to identify available treatment slots ( ) Yes (●) No

c) Expanded community network for supportive services and healthcare ( ) Yes (●) No

d) Inclusion of recovery support services ( ) Yes (●) No

e) Health navigators to assist clients with community linkages ( ) Yes (●) No

f) Expanded capability for family services, relationship restoration, and custody issues? ( ) Yes (●) No

g) Providing employment assistance (●) Yes ( ) No

h) Providing transportation to and from services (●) Yes ( ) No

i) Educational assistance (●) Yes ( ) No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The Division of Behavioral Health (DBH) contractually requires providers to admit pregnant women, arrange immediate admission with a different provider, and/or contact DBH to gain assistance in admitting the woman to an appropriate program.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

a)	90 percent capacity reporting requirement	(●) Yes ( ) No
b)	14-120 day performance requirement with provision of interim services	(●) Yes ( ) No
c)	Outreach activities	(●) Yes ( ) No
d)	Syringe services programs, if applicable	( ) Yes (●) No
e)	Monitoring requirements as outlined in the authorizing statute and implementing regulation	(●) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Electronic system with alert when 90 percent capacity is reached	( ) Yes (●) No
b)	Automatic reminder system associated with 14-120 day performance requirement	( ) Yes (●) No
c)	Use of peer recovery supports to maintain contact and support	( ) Yes (●) No
d)	Service expansion to specific populations (e.g., military families, veterans, adolescents, LGBTQI+, older adults)?	( ) Yes (●) No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The DBH contractually requires providers to admit individuals who inject drugs, arrange immediate admission with another provider, provide interim services and/or contact the DBH to gain assistance in admitting the individual to the appropriate program.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Business agreement/MOU with primary healthcare providers	( ) Yes (●) No
b)	Cooperative agreement/MOU with public health entity for testing and treatment	( ) Yes (●) No
c)	Established co-located SUD professionals within FQHCs	( ) Yes (●) No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The DBH continues to contractually require programs to develop/maintain working relationships with a healthcare provider, local health department or other professional entity for the providence of tuberculosis testing and provide for post-test counseling when tests are positive as well as provide education to the participants, their families, and their significant others regarding risks of tuberculosis. Data reports are utilized to collect information pertaining to the number of individuals with tuberculosis and the number of individuals that received post-test counseling.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring such service delivery? ( ) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Establishment of EIS-HIV service hubs in rural areas	( ) Yes ( ) No
b)	Establishment or expansion of tele-health and social media support services	( ) Yes ( ) No

c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS — ○ Yes ○ No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SUPTRS BG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)F)? — ◉ Yes ○ No

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? — ○ Yes ◉ No

3. Do any of the programs use SUPTRS BG funds to support elements of a Syringe Services Program? — ○ Yes ◉ No

If yes, plese provide a brief description of the elements and the arrangement

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Workforce development efforts to expand service access — (●) Yes ( ) No
- **b)** Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — ( ) Yes (●) No
- **c)** Establish a peer recovery support network to assist in filling the gaps — ( ) Yes (●) No
- **d)** Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — (●) Yes ( ) No
- **e)** Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — ( ) Yes (●) No
- **f)** Explore expansion of services for:
  - **i)** MOUD — (●) Yes ( ) No
  - **ii)** Tele-Health — (●) Yes ( ) No
  - **iii)** Social Media Outreach — ( ) Yes (●) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services — ( ) Yes (●) No
- **b)** Establish a program to provide trauma-informed care — (●) Yes ( ) No
- **c)** Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education — ( ) Yes (●) No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)? — (●) Yes ( ) No

2. Does your state provide any of the following:

- **a)** Notice to Program Beneficiaries — (●) Yes ( ) No
- **b)** An organized referral system to identify alternative providers? — ( ) Yes (●) No
- **c)** A system to maintain a list of referrals made by religious organizations? — ( ) Yes (●) No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Review and update of screening and assessment instruments — ( ) Yes (●) No
- **b)** Review of current levels of care to determine changes or additions — (●) Yes ( ) No

c) Identify workforce needs to expand service capabilities — (●) Yes ( ) No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — (●) Yes ( ) No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Training staff and community partners on confidentiality requirements — (●) Yes ( ) No

b) Training on responding to requests asking for acknowledgement of the presence of clients — ( ) Yes (●) No

c) Updating written procedures which regulate and control access to records — ( ) Yes (●) No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure: — ( ) Yes (●) No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? — (●) Yes ( ) No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

a) Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

All providers are nationally accredited, with the exception of two. Those accredited are not required to participate in a peer review per SAMHSA. Although, when an provider is experiencing challenges, regardless of accreditation status, a peer review may occur as a means to provide technical assistance to the provider. Two peer reviews are anticipated for FY 2023-2024. DBH is moving toward the requirement of national certification for Comprehensive Substance Treatment and Rehabilitation (CSTAR) program providers.

3. Has your state identified a need for any of the following:

a) Development of a quality improvement plan — ( ) Yes (●) No

b) Establishment of policies and procedures related to independent peer review — (●) Yes ( ) No

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations — (●) Yes ( ) No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? — (●) Yes ( ) No

If Yes, please identify the accreditation organization(s)

i) ☑ Commission on the Accreditation of Rehabilitation Facilities

ii) ☑ The Joint Commission

iii) ☑ Other (please specify)

Council on Accreditation

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? ○ Yes ◉ No

2. Has your state identified a need for any of the following:

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service ○ Yes ◉ No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing ○ Yes ◉ No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state ◉ Yes ○ No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services ◉ Yes ○ No

c) Performance-based accountability: ◉ Yes ○ No

d) Data collection and reporting requirements ◉ Yes ○ No

2. Has your state identified a need for any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs ○ Yes ◉ No

b) Addition of training sessions designed to increase employee understanding of recovery support services ○ Yes ◉ No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services ◉ Yes ○ No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort ○ Yes ◉ No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?

a) Prevention TTC? ○ Yes ◉ No

b) Mental Health TTC? ○ Yes ◉ No

c) Addiction TTC? ◉ Yes ○ No

d) State Targeted Response TTC? ○ Yes ◉ No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women ○ Yes ◉ No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

a) Tuberculosis ○ Yes ◉ No

b) Early Intervention Services Regarding HIV ○ Yes ◉ No

3. Additional Agreements

a) Improvement of Process for Appropriate Referrals for Treatment ○ Yes ◉ No

b) Professional Development ○ Yes ◉ No

c) Coordination of Various Activities and Services ○ Yes ◉ No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

General Program Procedures: https://s1.sos.mo.gov/cmsimages/adrules/csr/current/9csr/9c10-5.pdf
Core Rules for Psychiatric and SUD Treatment programs: https://s1.sos.mo.gov/cmsimages/adrules/csr/current/9csr/9c10-7.pdf
Substance Use Disorder Treatment Programs: https://s1.sos.mo.gov/cmsimages/adrules/csr/current/9csr/9c30-3.pdf
Mental Health Programs: https://s1.sos.mo.gov/cmsimages/adrules/csr/current/9csr/9c30-4.pdf

If the answer is No to any of the above, please explain the reason.

Footnotes:

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2022-FFY 2023? ○ Yes ◉ No

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma[1] is a common experience for adults and children in communities, and it is especially common in the lives of people with mental and substance use disorders. For this reason, the need to address trauma is increasingly seen as an important part of effective behavioral health care and an integral part of the healing and recovery process. It occurs because of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful and/or life-threatening experiences. Trauma has no boundaries regarding age, gender, socioeconomic status, race, ethnicity, geography, ability, or sexual orientation. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system and children and families in the child welfare system have high rates of mental illness, substance use disorders and personal histories of trauma. Similarly, many individuals in primary, specialty, emergency, and rehabilitative health care also have significant trauma histories, which impacts their health and responsiveness to health interventions. Also, schools are now recognizing that the impact of traumatic exposure among their students makes it difficult for students to learn and meet academic goals. As communities experience trauma, for some, these are rare events and for others, these are daily events. Children and families living in resource scarce communities remain especially vulnerable to experiences of trauma and thus face obstacles in accessing and receiving M/SUD care. States should work with these communities to identify interventions that best meet the needs of their residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink how practices are conducted. These public institutions and service settings are increasingly adopting a trauma-informed approach distinct from trauma-specific assessments and treatments. Trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues with a focus on equity and inclusion. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[2] paper.

[1] Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

[2] *Ibid*

Please consider the following items as a guide when preparing the description of the state's system:

1.	Does the state have a plan or policy for M/SUD providers that guides how they will address individuals with trauma-related issues?	(•) Yes ( ) No
2.	Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers?	(•) Yes ( ) No
3.	Does the state provide training on trauma-specific treatment and interventions for M/SUD providers?	(•) Yes ( ) No
4.	Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care?	(•) Yes ( ) No
5.	Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?	(•) Yes ( ) No
6.	Does the state use an evidence-based intervention to treat trauma?	(•) Yes ( ) No

7. Does the state have any activities related to this section that you would like to highlight.

The Department of Mental Health (DMH) and Missouri Trauma Roundtable developed, "Missouri Model: A Developmental Framework for Trauma Informed Approaches" in 2014, which provides guidance for organizations in their journey toward becoming trauma informed. Highlighting four stages - Trauma Aware, Trauma Sensitive, Trauma Responsive and Trauma Informed - it provides definitions, tasks, indicators and resources at each stage along with the continuum. Other states and countries around the world have used this model in various settings to aid organizations in creating trauma-informed care environments. Through a

SAMHSA-funded grant in 2021-22, DMH created virtual e-learning trauma informed care courses for helping professionals, adults and teens. The helping professional's course has had over 2,100 completions by various professionals working with traumatized populations.

Community Mental Health Centers (CMHC) and Certified Community Behavioral Health Organizations (CCBHO) participated in Trauma Informed Organizational Self-Assessment and consultation, and ongoing trauma informed learning collaborative. In 2021-2022, Women's & Children's Comprehensive Substance Treatment and Rehabilitation (CSTAR) providers participated in the Trauma Informed Organizational Self-Assessment and consultation in a 6 month-long trauma informed learning collaborative.

In 2022, the MHBG funded provider training for Eye Movement Desensitization and Reprocessing (EMDR). Additionally, MHBG funded, Habilitation, Empowerment Accountability Therapy (HEAT), and Habilitation, Empowerment and Recovery (HER) trainings, which are holistic, afro-centric strength based, trauma informed models that emphasize a positive and engaging approach to treatment. H.E.A.T. is a promising practice, manualized intervention created to address the specific needs of Black/African American males ages 18-29 with involvement in the criminal justice system. It is the only culturally responsive intervention of its kind in the country. Similarly, H.E.R. is a promising practice, therapeutic intervention created to address the specific needs of Black/African American women who have experienced victimization, have mild to moderate substance use disorders and who have current or past involvement with the criminal justice system. Training is designed for professional groups including: substance use treatment providers, case managers, probation/parole officers, program directors/supervisors, mental health professionals, and recovery coaches.

In the Behavioral Health Homes for individuals with chronic conditions, Missouri approved Complex Trauma as a condition that could qualify children and young adults, which would support early identification of and treatment for mental health, substance use and physical health conditions in an effort to decrease the likelihood of the development of chronic conditions and support resiliency and recovery.

Missouri Children's Trauma Network (MOCTN) is a network of clinicians and advocates dedicated to expanding access to evidence-based mental health treatment for traumatized children and youth. Recognizing that many Missouri children and youth experience abuse and neglect that often has life-long adverse consequences, the Network works to promote the healing of children and youth by: 1) training clinicians in evidence-based models, 2) improving screening, assessment and referral of traumatized children and youth, 3) identifying and working to address systematic barriers to implementation of evidence-based services and 4) collecting data on treatment outcomes to demonstrate value.

In 2023, MOCTN approved training for the following Evidenced Based Practices (EBPs) Motivational Interviewing (MI); Trauma-Focused CBT (TF-CBT); Problem Sexual Behavior CBT (PSB-CBT) and Eye Movement Desensitization and Reprocessing (EMDR) : In 2022, MOCTN funded the following EBP trainings: Integrated Treatment for Complex Trauma (ITCT), Child Family Traumatic Stress Intervention (CFTSI), Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS), Child Parent Psychotherapy (CPP) and Clinical Supervision Learning Collaborative. In 2023, MOCTN held the 6th Annual MOCTN Summit with an attendance of 484 professionals from behavioral health, developmental disabilities, child welfare, juvenile justice, pediatric healthcare and schools. Two hundred and ninety individuals attended the pre-conference on infant/early childhood trauma.

The DBH provided technical assistance and training to three CCBHO Parent Child Specialty Teams to enhance their infant/early childhood mental health and parent-child dyad skills to promote parental substance use recovery and prevent generational trauma and infant/young children from entering the foster care system.

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than a third of people in prisons and nearly half of people in jail have a history of mental health problems.[1] Almost two thirds of people in prison and jail meet criteria for a substance use disorder.[2] As many as 70 percent of youth in the juvenile justice system have a diagnosable mental health problem.[3] States have numerous ways that they can work to improve care for these individuals and the other people with mental and substance use disorders involved in the criminal justice system. This is particularly important given the overrepresentation of populations that face mental health and substance use disorder disparities in the criminal justice system.

Addressing the mental health and substance use disorder treatment and service needs of people involved in the criminal justice system requires a variety of approaches. These include:

- Better coordination across mental health, substance use, criminal justice and other systems (including coordination across entities at the state and local levels);
- Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups;
- Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system;
- Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community;
- Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems);
- Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, at booking, jails, the courts, at reentry, and through community corrections);
- Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system;
- Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met;
- Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges;
- Partnering with the judicial system to engage in cross-system planning and development at the state and local levels;
- Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system; and
- Supporting court-based programs, including specialty courts and diversion programs that serve people with M/ SUD.
- Addressing the increasing number of individuals who are detained in jails or state hospitals/facilities awaiting competence to stand trial assessments and restoration.

These types of approaches can improve outcomes and experiences for people with M/SUD involved in the criminal justice system and support more efficient use of criminal justice resources. The MHBG and SUPTRS BG may be especially valuable in supporting a stronger array of community-based services in these and other areas. SSAs and SMHAs can also play a key role in partnering with state and local agencies to improve coordination of systems and services. This includes state and local law enforcement, correctional systems, and courts. SAMHSA strongly encourages state behavioral health authorities to work closely with these partners, including their state courts, to ensure the best coordination of services and outcomes, especially in light of health disparities and inequities, and to develop closer interdisciplinary programming for justice system involved individuals. Promoting and supporting these efforts with a health equity lens is a SAMHSA priority.

[1]Bronson, J., & Berzofsky, M. (2017). Indicators of mental health problems reported by prisoners and jail inmates, 2011–12. Bureau of Justice Statistics, 1-16.

[2]Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2017). Drug use, dependence, and abuse among state prisoners and jail inmates, 2007–2009. Washington, DC: United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[3]Vincent, G. M., Thomas Grisso, Anna Terry, and Steven M. Banks. 2008. "Sex and Race Differences in Mental Health Symptoms in Juvenile Justice: The MAYSI-2 National Meta-Analysis." Journal of the American Academy of Child and Adolescent Psychiatry 47(3):282–90.

Please respond to the following items

1. Does the state (SMHA and SSA) engage in any activities of the following activities:

- [x] Coordination across mental health, substance use disorder, criminal justice and other systems
- [x] Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups
- [x] Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system, including those related to medications for opioid use disorder
- [x] Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- [x] Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- [x] Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community
- [x] Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems)
- [x] Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, booking, jails, the courts, at reentry, and through community corrections)
- [x] Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system
- [x] Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met
- [x] Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges
- [x] Partnering with the judicial system to engage in cross-system planning and development at the state and local levels
- [x] Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system
- [x] Supporting court-based programs, including specialty courts and diversion programs that serve people with M/SUD
- [x] Addressing Competence to Stand Trial; assessments and restoration activities.

2. Does the state have any specific activities related to reducing disparities in service receipt and outcomes across racial and ethnic groups for individuals with M/SUD who are involved in the criminal justice system? If so, please describe. (●) Yes ( ) No

The Division of Behavioral Health (DBH) and our partnering agency, the Missouri Behavioral Health Council (MBHC) have funded and coordinated several trainings for behavioral health staff on the Habilitation Empowerment Accountability Therapy (HEAT) program, which is a manualized, holistic, afro-centric, strength-based, trauma-informed model that emphasizes a positive and engaging approach to treatment.

3. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances? (●) Yes ( ) No

4. Does the state have any activities related to this section that you would like to highlight?

Community Behavioral Health Liaisons (CBHLs) assist law enforcement and the courts in addressing the behavioral health issues of individuals who come to the attention of the justice system in Missouri. The CBHL model saves valuable resources that might otherwise be expended on unnecessary jail, prison, and hospital stays and improves outcomes for individuals with behavioral health issues by connecting them to services, if appropriate. There are currently 81 CBHL positions who have assigned service areas, providing statewide coverage in Missouri. CBHLs provide no cost trainings to law enforcement officers focusing on substance use and mental health disorders education and reducing stigma. In fiscal year 2022, CBHLs received 22,438 referrals from law enforcement, courts, and jails. Of those referrals, 11,600 individuals were referred to behavioral health services.

The Missouri Crisis Intervention Team (CIT) program is a partnership with law enforcement and other first responders, behavioral health providers, hospitals, courts, individuals with lived experience, and community partners. The goal of CIT is to promote more effective law enforcement interactions with individuals in crisis, connect individuals in crisis with available resources, improve safety of the first responder and the individual in crisis, reduce stigma, and expand and sustain CIT across the state. There are 34 local CIT Councils and CIT officers in 110 of Missouri's 114 counties.

The Missouri Justice Reinvestment Initiative (JRI) Executive Oversight Committee (EOC) was formed in 2017 and continues to focus on violent crime, crisis response, criminal justice diversion, supporting victims of crime, strengthening community-based treatment, implementing evidence-based practices in the Missouri Department of Corrections (DOC), and modernize parole decision-making. The JRI EOC includes directors from the executive branch, senators and house members from the legislative branch, a Supreme Court judge, the governor's office, and local law enforcement officials. The Department of Mental Health (DMH) Director is the co-chair of the JRI EOC. Through JRI, the DMH formed a partnership MBHC, the Office of State Courts Administrator (OSCA), National Center for State Courts (NCSC), and Policy Research Associates (PRA) to conduct a Sequential Intercept Model (SIM) Mapping Workshop in every county/judicial circuit in Missouri through April 2025. A Mapping Workshop brings together a team of local stakeholders and utilizes the SIM tool in strategic planning to assess available resources, identify gaps/challenges in accessing services, and establish a plan for community change (and ultimately statewide change). The SIM tool was developed to focus on those "intercepts" at each point in the justice system (including prior to law enforcement involvement) to improve cross-system collaborations and reduce involvement in the justice system by those with behavioral health disorders. Statewide systems-level solutions and trends in needs will be included in future JRI Annual Reports to the Governor.

The DMH Director is a member of the Missouri Treatment Courts Commission who provides oversight for the operations and funding for the 133 treatment court programs in Missouri.

Please indicate areas of technical assistance needed related to this section.

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14. Medications in the Treatment of Substance Use Disorders, Including Medication for Opioid Use Disorder (MOUD) – Requested (SUPTRS BG only)

Narrative Question

In line with the goals of the Overdose Prevention Strategy and SAMHSA's priority on Preventing Overdose, SAMHSA strongly request that information related to medications in the treatment of substance use disorders be included in the application.

There is a voluminous literature on the efficacy of the combination of medications for addiction treatment and other interventions and therapies to treat substance use disorders, particularly opioid, alcohol, and tobacco use disorders. This is particularly the case for medications used in the treatment of opioid use disorder, also increasingly known as Medications for Opioid Use Disorder (MOUD). The combination of medications such as MOUD; counseling; other behavioral therapies including contingency management; and social support services, provided in individualized, tailored ways, has helped countless number of individuals achieve and sustain remission and recovery from their substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based, or non-medication inclusive, treatment for these conditions. The evidence base for medications as standards of care for SUDs is described in SAMHSA TIP 49 Incorporating Alcohol Pharmacotherapies Into Medical Practice and TIP 63 Medications for Opioid Use Disorders.

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to offer MOUD and medications for alcohol use disorder or have collaborative relationships with other providers that can provide all FDA-approved medications for opioid and alcohol use disorder and other clinically needed services.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs. States should use Block Grant funds for the spectrum of evidence-based interventions for opioids and stimulants including medications for opioids use disorders and contingency management.

In addition, SAMHSA also encourages states to require equitable access to and implementation of medications for opioid use disorder (MOUD), alcohol use disorder (MAUD) and tobacco use disorders within their systems of care.

SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding the use of medications for substance use disorders? (●) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of medications for substance disorder, including MOUD, within special target audiences, particularly pregnant women? (●) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds?

- **a)** ☑ Methadone
- **b)** ☑ Buprenophine, Buprenorphine/naloxone
- **c)** ☑ Disulfiram
- **d)** ☑ Acamprosate
- **e)** ☑ Naltrexone (oral, IM)
- **f)** ☑ Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based treatment with the use of FDA-approved medications for treatment of substance use disorders is combined with other therapies and services based on individualized assessments and needs? (●) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight?

Contracted Providers with the Department of Mental Health (DMH), Division of Behavioral Health (DBH) are required to make available, either through direct prescribing or via referral arrangements, all Food and Drug Administration (FDA) approved medications for the treatment of Alcohol Use Disorder (AUD) and Opioid Use Disorders (OUD). DBH contracted providers are able to provide medication services via telehealth, which allows for increased access to Medication Assisted Treatment (MAT) in all areas of the state, with particular utility in Missouri's rural areas. By utilizing federal opioid crisis grant dollars Missouri's State Targeted Response to the Opioid Crisis (STR) and State Opioid Response (SOR) team developed and disseminated the Medication First

treatment approach in accordance with Medication First core principles, including providing pharmacotherapy as quickly as possible without tapering or time limits, continually offering but not requiring psychosocial service participation, and not discontinuing MAT unless it is worsening the individual's condition. Missouri continues to collaborate on innovative ways to increase access to quality OUD treatment for specialty populations, including providing training and technical assistance on OUD care for pregnant and postpartum women, providing peer-based linkage to care in the emergency room through the Engaging Patients in Care Coordination (EPICC) program, contingency management for stimulant use disorder, and the Opioid Use Disorder (OUD) Justice Initiative that provides medication assisted treatment for OUD to individuals in the St. Louis County Jail, the largest county jail in the state.

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15. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress to set aside 5 percent of the Mental Health Block Grant (MHBG) allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *....to support evidenced-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to expend some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expanding 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization service to support reducing distress, promoting skill development and outcomes, manage costs, and better invest resources.

SAMHSA developed **Crisis Services: Meeting Needs, Saving Lives**, which includes "**National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit**" as well as an **Advisory: Peer Support Services in Crisis Care** and other related National Association of State Mental Health Programs Directors (NASMHPD) papers on crisis services. SAMHSA also developed "**National Guidelines for Child and Youth Behavioral Health Crisis Care**" which offers best practicies, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by this new 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

1. Briefly narrate your state's crisis system. For all regions/areas of your state, include a description of access to the crisis call centers, availability of mobile crisis and behavioral health first responder services, utilization of crsis receiving and stabilization centers.

Since its national launch in July of 2022, the 988 Suicide & Crisis Lifeline has played a vital role in providing rapid access to crisis services for individuals experiencing mental health, suicide, or substance use crises. In Missouri, the Division of Behavioral Health (DBH), behavioral health providers, and community partners have been working diligently to establish a comprehensive "no-wrong-door" integrated crisis response system. This collaborative effort aims to prevent tragedies, save lives, and optimize resource utilization. Missouri's vision is to build an evidence-based care continuum to deliver high-quality community based crisis services statewide with the 988 at its core.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

*a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
*b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the SAMHSA guidance. This includes coordination, training and community outreach and education activities.*
*c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the SAMHSA*

guidelines.

*d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.*

*e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Other program implementation data that characterizes crisis services system development.

1. Someone to talk to: Crisis Call Capacity

- *a. Number of locally based crisis call Centers in state*
  - *i. In the 988 Suicide and Crisis lifeline network*
  - *ii. Not in the suicide lifeline network*
- *b. Number of Crisis Call Centers with follow up protocols in place*
- *c. Percent of 911 calls that are coded as BH related*

2. Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)

- *a. Independent of first responder structures (police, paramedic, fire)*
- *b. Integrated with first responder structures (police, paramedic, fire)*
- *c. Number that employs peers*

3. Safe place to go or to be:

- *a. Number of Emergency Departments*
- *b. Number of Emergency Departments that operate a specialized behavioral health component*
- *c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis)*

a. Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to talk to	☐	☐	☐	☐	☐	☑
Someone to respond	☐	☐	☐	☐	☐	☑
Safe place to go or to be	☐	☐	☐	☐	☑	☐

b. Briefly explain your stages of implementation selections here.

In accordance with the guidelines, the 988 Suicide & Crisis Lifeline has reached program sustainment. Over the past few years, Missouri has expanded its National Suicide Prevention Lifeline members from three to seven. These centers are now responsible for handling all 988 calls, chats, and texts that occur in the state 24/7. Missouri is leading a 988 Task Force that is made up of behavioral health leaders and advocates who have come together to implement 988 into Missouri's larger behavioral health system of care. Planning elements included meeting, maintaining, and improving capacity, funding, and infrastructure to achieve better outcomes for Missourians in crisis. With 988 highlighting the opportunity for expansion of crisis care in Missouri, the DBH partnered with 988 to

3. Based on SAMHSA's National Guidelines for Behavioral Health Crisis Care, explain how the state will develop the crisis system.

SAMHSA's National Guidelines for Behavioral Health Crisis Care were followed when drafting Missouri's BHCC regulations. These national guidelines will be followed when drafting the 988 and mobile crisis response regulations as well. Missouri crisis services follow all minimum expectations and strive to follow many best practices established in the guides.

4. Briefly describe the proposed/planned activities utilizing the 5 percent set aside.

The crisis services set aside will focus on the crisis care needs of individuals experiencing a behavioral health crisis. It will be used to support core crisis care service components such as "someone to talk to", "someone to respond" and/or "somewhere to go". Proposed activities include support of wrap around services, transportation, crisis residential services, and to support the transition from the Access Crisis Intervention local hotlines to 988.

Please indicate areas of technical assistance needed related to this section.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

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16. Recovery - Required

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders.

Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery- guided the approach to person-centered care that is inclusive of shared decision-making, culturally welcoming and sensitive to social determinants of health. The continuum of care for these conditions involves psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder, and services to reduce risk related to them. Because mental and substance use disorders can become chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management recovery and personal success over the lifespan.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

a)	Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?	(•) Yes ( ) No
b)	Required peer accreditation or certification?	(•) Yes ( ) No
c)	Use Block grant funding of recovery support services?	(•) Yes ( ) No
d)	Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?	(•) Yes ( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? (•) Yes ( ) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Clubhouses
Drop-in centers
Peer specialists
Peer wellness coaching
Family navigators/parent support partners/providers
Peer-delivered motivational interviewing
Self-directed care
Supportive housing models
Evidenced-based supported employment
Wellness Recovery Action Planning (WRAP)
Shared decision making
Person-centered planning
Self-care and wellness approaches
Room and board when receiving treatment

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations

Recovery community centers
Recovery Support Services
Recovery Housing
Peer Respite
Peer-Run Organizations
Peer recovery coaching Peer wellness coaching
Family navigators/parent support partners/providers
Peer-delivered motivational interviewing
Telephone recovery checkups
Self-directed care
Supportive housing models
Evidenced-based supported employment
Wellness Recovery Action Planning (WRAP)
Person-centered planning
Self-care and wellness approaches
Room and board when receiving treatment

5. Does the state have any activities that it would like to highlight?

The Division of Behavioral Health (DBH) remains committed to the development and sustainability of Recovery Support Services and Consumer Operated Service Programs.

Peer Support: Peer support services are available to individuals in behavioral health treatment. These services are face-to-face services or group services with a recovery focus. Peer Specialists can share lived experiences of recovery, share and support use of recovery tools, and model successful recovery behaviors. Peer support services are Medicaid-reimbursable for mental health treatment. Missouri currently has over 1,500 Certified Peer Specialists.

Family Support: Family support is a peer support service provided to parents and caregivers of children, youth, and young adults (18-25). Trained Family Support Specialists with lived experience provide individualized, one-on-one supports and services to the parents or caregivers. This may include providing information and resources to help the family better understand what is happening with their child/youth. They also provide support to help the parents or caregivers develop problem-solving strategies and assistance in navigating the service system.

Drop-In Centers: DBH's Consumer-Operated Services Programs (COSPS) are peer-run service programs that are administratively

controlled and operated by mental health consumers and emphasize self-help as their operational approach. The DBH funds four Drop-In Centers that provide a safe place where individuals can go to find recovery programs and services provided by their peers. DBH funds one statewide peer phone support "Warm Line."

NAMI Support Groups: DBH funds statewide NAMI Missouri Family-to-Family support groups, NAMI Basics, NAMI Ombudsman, and NAMI Provider Education Program trainings.

Recovery Support Services: Recovery support programs offer services such as care coordination, recovery coaching, spiritual counseling, group support, recovery housing and transportation, before, during, after, and in coordination with other substance use disorder service providers. These services are offered in a multitude of settings including community, faith-based and peer recovery organizations. Recovery support programs are person-centered and self-directed allowing individual's choice of provider.

Recovery Community Centers: DBH received a SAMSHA State Opioid Response (SOR) grant for the purpose of expanding access to integrated prevention, treatment, and recovery support services for individuals with opioid use disorder throughout the state, including development of local Recovery Community Centers (RCC). Four SOR funded RCCs provide a peer-based supportive community that builds hope and supports healthy behaviors for individuals with Opioid Use Disorders (OUDs) and Stimulant Use Disorders searching for recovery or maintaining recovery. Four additional RCCs are being funded with the Block Grant Supplemental funding.

Employment: DBH works to integrate clinical and vocational supported employment services through statewide partnerships with the Office of Adult Learning & Rehabilitation Services (Vocational Rehabilitation – VR) and provider agencies. The goal is to help individuals who are interested in employment participate in the competitive labor market in a job of their preference with the appropriate level of professional help needed to be successful. DBH has 33 community treatment programs designated as VR funded Community Rehabilitation Programs to provide supported employment services. Technical assistance, training, and fidelity reviews are conducted to ensure fidelity to the model. DMH supports the usage of Disability Benefits 101, which is a Missouri specific online tool designed to provide information on health coverage, benefits, and employment. The tool also provides information for veterans and youth interested in higher education.

Wellness: DBH has provided and will continue to provide training on Wellness Recovery Action Plan (WRAP).

Housing Supports: Housing is a critical component for recovery and wellness. The DBH Housing Unit coordinates both state and federal funds to provide direct rental assistance to individuals and families with mental illness, substance use disorders, developmental disabilities, and HIV/AIDS who are homeless or experiencing housing crisis. The DBH believes that housing is a key to helping Missourians with disabilities and their families attain self-determination and independent living. A full array of housing options are available from residential care facilities to independent apartments. Recovery housing provides a safe, healthy environment that support residents in their recovery from substance use disorders. DMH contracts with the Missouri Coalition of Recovery Support Providers to accredit Recovery Housing using the National Alliance for Recovery Residences quality standards. Currently, there are 188 Recovery Houses with 2,124 beds accredited.

Please indicate areas of technical assistance needed related to this section.

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17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Does the state's Olmstead plan include:

Housing services provided	(•) Yes	( ) No
Home and community-based services	( ) Yes	(•) No
Peer support services	(•) Yes	( ) No
Employment services.	(•) Yes	( ) No

2. Does the state have a plan to transition individuals from hospital to community settings? (•) Yes ( ) No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

The DBH will continue to strive to meet the integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999). DBH regional staff conduct Least Restrictive Environment Reviews to assure individuals served are residing in appropriate settings. DBH works closely with the Governor's Council on Disability to coordinate and partner with other agencies on housing and employment. DBH will continue to work closely with our HUD Continuums of Care and Coordinated Entry systems to coordinate affordable housing. DBHs Mission is "Serving, empowering and supporting Missourians to live their best lives." Our Vision is "Missourians are safe, valued and supported community members."

Please indicate areas of technical assistance needed related to this section.

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18. Children and Adolescents M/SUD Services –Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[1]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[2]. For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[4].

Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[5].

According to data from the 2017 Report to Congress[6] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system.
2. improve emotional and behavioral outcomes for children and youth.
3. enhance family outcomes, such as decreased caregiver stress.
4. decrease suicidal ideation and gestures.
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and

employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

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[1]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[2]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[3]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[4]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[5]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[6] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery of children and youth with SED? (●) Yes ( ) No

b) The resilience of children and youth with SED? (●) Yes ( ) No

c) The recovery of children and youth with SUD? (●) Yes ( ) No

d) The resilience of children and youth with SUD? (●) Yes ( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? (●) Yes ( ) No

b) Health care? (●) Yes ( ) No

c) Juvenile justice? (●) Yes ( ) No

d) Education? (●) Yes ( ) No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? (●) Yes ( ) No

b) Costs? (●) Yes ( ) No

c) Outcomes for children and youth services? (●) Yes ( ) No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? (●) Yes ( ) No

b) Mental health treatment and recovery services for children/adolescents and their families? (●) Yes ( ) No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? (●) Yes ( ) No

b) for youth in foster care? (●) Yes ( ) No

c) Is the child serving system connected with the FEP and Clinical High Risk for Psychosis (CHRP) systems? (●) Yes ( ) No

d) Does the state have an established FEP program? (●) Yes ( ) No

Does the state have an established CHRP program? (●) Yes ( ) No

e) Is the state providing trauma informed care? (●) Yes ( ) No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

Through local system of care teams across the state, the Department of Mental Health (DMH), Division of Behavioral Health (DBH) works with Missouri's children and/or youth serving systems, families and children/youth to collaborate and coordinate behavioral health services. The function of system of care teams include: addressing system and community barriers to appropriate

services; providing expert recommendations and data to public policy makers as it relates to the needs of children/youth and families; advocating for prevention, early intervention and treatment recovery; ensuring clinically appropriate integrated services are available and provided; and/or increasing access and family engagement in all services to children/youth and families. Local System of Care teams are made up of family members, family run organizations, DBH, Department of Health and Senior Services (DHSS), Department of Social Services (DSS)/Children's Division (CD), Department of Elementary and Secondary Education (DESE), Juvenile Justice and other local child serving agencies. The Children's Director provides oversight of an inclusive DMH Children's Team which is structured to coordinate behavioral health and supports for intellectual and developmental disabilities services across the DBH and Developmental Disabilities Divisions in DMH to better support all Missouri youth. The Children's Team, under the supervision of the Children's Director, draws experts within DMH together to create and maintain behavioral health policies and clinical practices that support and promote positive outcomes for children/youth and families in Missouri, no matter what their point of entry into DMH services.

7. Does the state have any activities related to this section that you would like to highlight?

Family Support Providers (FSPs) allow caregivers to receive assistance while their children and/or youth receive treatment of behavioral or substance use disorders. These FSPs assist parents and caregivers in working through problems encountered during the time that the child/youth receives a diagnosis which is when support is needed the most. Problem solving tools, self-esteem building, and working through fears are just a few of the areas in which FSPs may help parents/caregivers. Youth Peer Support Specialists support, encourage, and model positive self-advocacy, recovery and resiliency for youth ages 13-25. The DBH requires all Youth Peer Support Specialists providing services to youth under the age of 18 to be certified in youth peer support. A nationally recognized training curriculum with content specifically geared to the youth and young adult population is utilized. Youth Peer Support Specialists understand youth culture through traditional education and through the knowledge they gain from their lived experience. As a result of the MO TAYLER: Missouri Transition Aged Youth Local Engagement & Resources initiative the DBH aims to improve access to treatment, increase emotional and behavioral health functioning, and maximize potential to assume adult roles and responsibilities, and lead full, productive lives for youth and young adults ages 16-25. Providers have access to resources supporting culturally competent, developmentally appropriate services and intervention approaches to youth and young adults with serious mental disorders in three Missouri communities. In addition, these strategies and lessons learned will continue to be shared across the state. To enhance collaborative, community-based services provided to youth, DMH will work with Community Mental Health Centers (CMHC) and Certified Community Behavioral Health Organizations (CCBHO) to establish Youth Behavioral Health Liaisons (YBHL). A YBHL is a mental health professional who forms local community partnerships with various youth-serving organizations to address specific behavioral health needs of vulnerable children and youth. The YBHL will function as a service connector for youth with co-occurring mental illness, substance use, and/or a developmental disability to link youth to services available through community partners. A primary goal in establishing YBHLs is to form better community partnerships between CMHCs, CCBHOs, substance use treatment providers, Juvenile Office and Family Courts, Children's Division, and hospitals to help improve outcomes for youth with behavioral health issues. YBHLs will work to divert youth from inpatient hospitalization and out-of-home placements such as residential treatment centers, juvenile detention, while supporting youth in natural family and/or community-based settings. Through their interactions with the YBHLs, youth and families with behavioral health issues and developmental disabilities who have frequent interaction with Children's Division, Juvenile and Family Courts, law enforcement, and inpatient hospitals will have improved access to behavioral health treatment.

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death overall, with over 47,000 people dying by suicide in 2021 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following:

1. Have you updated your state's suicide prevention plan in the last 2 years? ○ Yes ◉ No

2. Describe activities intended to reduce incidents of suicide in your state.

1. The Implementation of the 988 Suicide & Crisis Lifeline & Enhancement of Statewide Behavioral Health Crisis Services

The 988 Suicide & Crisis Lifeline is a three-digit dialing code for anyone experiencing a mental health, suicide, or substance use crisis. DMH, alongside behavioral health providers and community partners, has been working diligently to establish a comprehensive "no-wrong-door" integrated crisis response system. This effort aims to prevent tragedies, save lives, and optimize resource utilization. Missouri's vision is to build an evidence-based care continuum to deliver high-quality community-based crisis services statewide with the 988 Suicide & Crisis Lifeline at its core.

DMH contracts with seven 988 centers in Missouri to offer 24/7, statewide coverage for 988 calls, texts, and chats. Since 988 implementation in July of 2022, Missouri witnessed a steady and continuous rise in the demand for 988 services. In FY23, Missouri's 988 centers answered 46,647 calls, 5,419 texts, and 7,666 chats. Missouri's average in-state call answer rate for FY23 was 91%.

2. Statewide 988 Campaign
In FY2022, the Division of Behavioral Health (DBH) contracted with Learfield to conduct a statewide 988 public education and awareness campaign. Campaign activities include advertisement through radio, broadcast and streamed television, and in magazines. Activities also include promotion on local transit, billboards, signage at high school and collegiate events, and on all social media platforms (Facebook/Instagram, Google, YouTube, Spotify, Pandora, TikTok, and Snapchat). In addition, DBH worked with Learfield to create a Missouri 988 website, 988 e-Learning modules, virtual and physical toolkits, and educational and promotional materials. This campaign aims to reduce suicides in Missouri as well as promote messages of hope and that help is available.

3. Suicide Prevention & 988 Guide for Missouri Schools
The DBH partnered with the Suicide Prevention in Schools Committee of the Missouri Suicide Prevention Network (MSPN) to create the "Suicide Prevention & 988 Guide" for Missouri Schools. The guide is intended for school personnel to utilize suicide prevention, intervention and crisis response services, and postvention resources to better address and meet the needs of schools across the state. While the guide is most applicable to middle and high school settings, elementary and higher education considerations are included as well.

4. Cooperative Agreement to Implement Zero Suicide in Health Systems (Adult Zero Suicide Grant)
Under the Adult Zero Suicide Grant, Missouri is integrating the Zero Suicide model into multiple health systems by:
1) Improving care coordination in emergency departments and hospitals;
2) Strengthening the state's crisis hotlines;
3) Expanding Zero Suicide in the statewide behavioral healthcare system and its associated referral systems; and
4) Developing a statewide collaborative to guide policy and develop protocol for zero suicide prevention planning in Missouri.

This project is serving adults age 25 and older who have behavioral health disorders, adults and their families experiencing crisis, and Missouri veterans at risk but not currently served by the Veterans Health Administration. An intensive care coordination model is being piloted in Missouri's two largest urban cities, Kansas City and St. Louis, through partnerships with local behavioral health providers and 18 hospitals/emergency departments.

5. Signs of Suicide (SOS) Training
The DBH contracted Prevention Resource Center (PRC) staff have been trained as Signs of Suicide (SOS) Trainers. SOS is an evidence-based youth suicide prevention program that has demonstrated an improvement in students' knowledge and adaptive attitudes about suicide risk and depression. The PRCs provide this training to school staff across the state. This curriculum helps

students identify the warning signs and risk factors of depression and suicidal ideation in themselves and others.

6. Zero Suicide Initiative
The DBH held its 6th annual Zero Suicide Academy in FY23 with 15 organizations in attendance. The Zero Suicide Academy is a two -day training for senior leaders of health and behavioral health care organizations that seek to dramatically reduce suicides among patients in their care. Using the Zero Suicide framework, participants learn how to incorporate best and promising practices into their organizations and processes to improve care and safety for individuals at risk. Zero Suicide faculty provide both interactive presentations and small group sessions, collaborating with participants to develop organization-specific action plans. Following the Academy, DBH and Missouri Zero Suicide leaders convene bi-monthly Zero Suicide Learning Collaboratives for all attendees of the Academy to provide ongoing support and technical assistance to providers working to implement the Zero Suicide framework into their organizational systems.

7. Show Me Zero Youth Suicide Initiative
The "Show Me Zero Youth Suicide" initiative aims to reduce youth suicide through an integrated systems-level approach, which includes establishing a continuity of care model for youth at risk of suicide and promoting the adoption of suicide prevention as a core priority of youth-serving institutions, such as hospitals and schools. Through collaboration with a local behavioral health provider, this initiative is effectively identifying youth ages 10-24 who are at risk for suicide and providing them immediate linkage to intensive services and follow-up care. Services are being focused on a five county region in western Missouri, centered on Jackson County, which includes Kansas City, as well as the surrounding counties with more rural areas. The overall aim of the "Show Me Zero Youth Suicide" initiative is to reduce suicides and suicide attempts in youth by accomplishing three major goals:
1) Improve the system of care of suicidal youth who use hospital emergency departments;
2) Improve the capacity of school system to identify, respond, and refer youth at risk of suicide; and
3) Strengthen overall prevention efforts for at-risk youth populations in other settings.

8. Missouri State Suicide Prevention Plan
In 2018, the DBH collaborated with the Missouri Behavioral Health Council (MBHC) to create an independent, non-partisan, voluntary group of individuals and organizations to lead and coordinate statewide suicide prevention efforts. The Missouri Suicide Prevention Network (MSPN) is comprised of and working with several state partners from the public and private sectors to also coordinate and develop implementation of the Missouri Suicide Prevention Plan, based on the National Strategy for Suicide Prevention. In FY23, Missouri began planning for the 2024-2028 State Suicide Prevention Plan. The three main priorities of this upcoming plan include:
1) Raising public awareness about suicide risk, prevention, and resources;
2) Supporting community-led coalitions and efforts; and
3) Engaging diverse populations and sectors in implementing suicide prevention programs, systems, and policies.

9. Suicide Prevention in Health Care ECHO
The Suicide Prevention in Health Care ECHO educates and empowers providers to competently and confidently treat individuals at risk for suicide. A multidisciplinary team of mental health experts convene bi-monthly meetings to share information about best practices, plans, and procedures. Primary care and emergency medicine providers, school officials, law enforcement personnel, and other professionals who interact with the mental health community are encouraged to participate.

3. Have you incorporated any strategies supportive of Zero Suicide? (●) Yes ( ) No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? (●) Yes ( ) No

If yes, please describe how barriers are eliminated.

The Adult Zero Suicide Program connects individuals who are experiencing suicide ideation and attempts to service providers in hospitals and the community. An intensive care coordination model is utilized for this project. The DBH works with behavioral health providers in Kansas City and St. Louis to provide intensive care coordination to adults at risk of suicide. Providers offer this intervention and care coordination in both the hospital and community setting, and they work with multiple hospital systems and other community providers to receive referrals and offer post care connection. The program started in the fall of 2018. In 2022, by the end of year 4 of the grant, a total of 3,161 individuals have been referred to the program. Of the individuals referred, 1,730 were screened, and 1,506 accepted services through the program. Key outcome measures were collected at intake and 3 months after intake. Analysis indicated that those participating in the program experienced a decrease in number of attempts, hospitalizations, and emergency department visits. Additionally, suicidal ideation as identified on the C-SSRS decreased over the 3 month period.

5. Have you begun any prioritized or statewide initiatives since the FFY 2022 - 2023 plan was submitted? (●) Yes ( ) No

If so, please describe the population of focus?

The DBH has launched a statewide 988 campaign aimed at spreading awareness of the 988 Suicide & Crisis Lifeline. Although the campaign is intended to spread awareness and increase understanding of the Lifeline for all Missourians, increased promotion and awareness activities have been targeted to certain groups and communities across Missouri who may be at higher risk for suicide, such as Veterans, Service Members, and their Families (SMVF), youth and young adults, and more.

The Suicide Prevention & 988 Guide for Missouri Schools was developed in fall of 2022 to support school staff and faculty with their suicide prevention efforts.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The State Medicaid Authority agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and M/SUD conditions.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- SAMHSA seeks to enhance the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states. In many respects, successful implementation is dependent on leadership and collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? (●) Yes ( ) No

2. Has your state identified the need to develop new partnerships that you did not have in place? (●) Yes ( ) No

If yes, with whom?

Supporting Young People Meetings
Missouri Coordinated School Health Coalition Higher Ed Taskforce
Higher Education Task Force
The Missouri Interagency Transition Team
Workforce Innovation and Opportunity Act Committee
Missouri Interagency Transition Team
Missouri School Safety Academy Advisory Council
Missouri Suicide Prevention State Plan Writing Workgroup
Tobacco Prevention and Control Strategic Plan Prevention Workgroup
988/911 Committee
Missouri Zero Suicide Learning Collaborative

Missouri Suicide Prevention Stakeholder Meeting
Missouri Crisis Services Committee
Show Me Farm Safety Committee
Prescription Medication Advisory Committee (DSS)

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

The Department of Mental Health (DMH) is partnering with the Department of Elementary and Secondary Education (DESE), Missouri Head Start, Department of Health and Senior Services (DHSS) and Department of Social Services (DSS) to support the new Office of Childhood in Missouri. The office will ensure that children and families in Missouri have better access to more consistent, quality programs and services that support early childhood care and education, early learning, early intervention, and positive social and emotional development.

The DMH has also enhanced partnerships with other state agencies, including Department of Natural Resources (DNR) in terms of suicide prevention projects and additionally DMH providing an externship where a DMH staff spent a specified amount of time with DNR and their visiting their parks to learn and give guidance on suicide and trauma in the state parks. MU Extension has collaborated with DMH to work toward Recovery Friendly Workplaces. Additionally, DMH has been working closely with Missouri Primary Care Associate (MPCA) this past year on integration efforts involving our community treatment providers and the Federally Qualified Health Centers.

DMH is also partnering with DESE on their Project AWARE grant. Together, along with three local education agencies we will increase awareness of mental health issues among school-aged youth, provide training for school personnel and other adults who interact with school-aged youth to detect and respond to mental health issues, and connect school-aged youth who may have behavioral health issues and their families, to needed services.

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance use disorder Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SUPTRS BG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[1]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[1] **https://www.samhsa.gov/grants/block-grants/resources [samhsa.gov]**

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc.)

A presentation on the Mental Health & Substance Use Block Grants FY2024-2025 was given to the SAC at the April 5th, 2023 meeting. An allotted time was given for SAC members to ask questions and provide comments. A letter of support was signed at the June 7th, 2023 SAC meeting. Agendas, Meeting Minutes and handouts are available on the DMH website page dedicated to the SAC: https://dmh.mo.gov/alcohol-drug/state-advisory-council
See attached meeting minutes & letter of support.

2. What mechanism does the state use to plan and implement community mental health treatment, substance misuse prevention, SUD treatment, and recovery support services?

As of 2018, Missouri's two separate planning councils merged into one planning council with two subcommittees. The State Advisory Council on Alcohol and Drug Abuse (SAC-ADA) and State Advisory Council on Comprehensive Psychiatric Services (SAC-CPS) merged to become the Division of Behavioral Health (DBH) State Advisory Council (SAC). The SAC consists of up to 32 members who have a professional, research, or personal interest in prevention, recovery, evaluation, treatment rehabilitation, and system of care for children and youth with serious emotional disturbance and persons affected by behavioral health disorders and their families. The SAC shall include service providers, consumers (recipients of services or family members of recipients), and other interested citizens. The SAC shall include representatives from non-government organizations or groups and state agencies concerned with the planning, operation or use of behavioral health services; individuals with mental health and/or substance use disorders who are receiving or have received behavioral health services and who are familiar with the need for such services; and family members of adults with mental health and/or substance use disorders or families of children with emotional disturbance. At least one member shall represent veterans and military affairs. At least one-half of the members of the SAC shall be recipients of behavioral health services or family members of recipients. No more than one-half of the members of SAC shall be providers as defined as an entity/service delivery system, which uses, purchases and/or coordinates with mental health, substance use, or developmental disabilities services provided by contracts with the Department of Mental Health (DMH). Representatives of state agencies responsible for mental health, education, vocation rehabilitation, criminal justice, housing, social services and Medicaid are mandated. Membership terms are three years and a member may serve an additional three year term if nominated and approved by the SAC and the DBH Director. The SAC shall recognize two standing committees, the Mental Health Disorders Committee and the Substance Use Disorders Committee. The purpose of these committees is to ensure adequate representation and focus on the issues unique to each committee. The co-chairpersons of these standing committees shall equally share the leadership of the full SAC. The mission of the SAC is to advise the DBH in the development, funding, prevention, public understanding and coordination of specialized services to meet the needs of Missourians with mental health and substance use disorders. In order to accomplish this mission the SAC shall collaborate with the DBH to develop and review the state plans for delivering behavioral health services pursuant to Title 42, 300x-3 (Federal statute) and CSR 631.020.8.; advise DBH in the development of models of services and long range planning and

budgeting priorities; identify statewide needs and recommend what specific methods, means, and procedures should be adopted to improve and upgrade the behavioral health service delivery system for citizens of this state; provide education and information about mental health and substance use; monitor, evaluate, and review the allocation and adequacy of behavioral health services within the state; and provide oversight for suicide prevention activities.

3. Has the Council successfully integrated substance misuse prevention and SUD treatment and recovery or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

4. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? (●) Yes ( ) No

5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The SAC provides a diverse perspective on the prevention and treatment of substance use and mental health. SAC meetings include updates, presentations, and discussions from the DBH Director and/or her representative and section heads from prevention, treatment, recovery, and fiscal units. In addition, the SAC receives regular briefings and feedback from the Missouri National Alliance on Mental Illness, Missouri Protection & Advocacy, and Children's Services. The SAC also receives regular briefings from the Missouri Credentialing Board on matters pertaining to professional credentialing and workforce development.

Additionally, the SAC serves as an advocate for adults with serious mental illness, children with severe emotional disturbance, and other individuals with mental illness or emotional problems. SAC advocacy activities include promoting the Consumer/Family/Youth Conference as well as Peer Specialist training and certification. Through this process, individuals served can learn to identify their strengths and personal resources, learn to make independent choices, and take a proactive role in their treatment. The SAC coordinates recommendations on behavioral health services, including recommendations for Missouri's FY 2023-2023 Behavioral Health Assessment and Plan and the State Suicide Prevention Plan. In addition to the regular briefings, the SAC has been audience to presentations from numerous experts in areas from Jail-based competency restoration, to patient application services from Department of Health and Senior Services (DHSS), Division of Cannabis regulation, Division of Developmental Disabilities (DD) Health Home, and School-based services.

The SAC currently has three project subcommittees, which address special issues identified by the SAC or the DBH as topics relevant to the SAC purpose, authority or to the behavioral health delivery system. See attached. In addition to the on-going work these subcommittees are doing, the SAC accomplished the following over the past year:
1. Created a SAC logo-attached;
2. Submitted consequences and recommendations via a white paper to the DBH regarding cannabis legalization in the state; and
3. Made recommendations to the DBH for a grant program to utilize some of the opioid settlement dollars to support prevention and recovery support service.
The SAC supports Real Voices Real Choices, which is the annual consumer conference to educate, inform, and empower individuals in treatment and/or recovery and their families. This conference developed from Missouri's Mental Health Transformation Grant, a SAMHSA-funded grant that ended in 2011. The 2022 conference was held in person in August. There was a newly added Peer Track and there was great participation. The 2023 conference will be held in-person and in August as well. The SAC encourages and fosters the advancement of this annual event.

The SAC endorses the Missouri's Mental Health Champions – an effort to recognize the accomplishments of individuals whose lives have been challenged by mental illness, substance use disorders, and/or developmental disabilities. The 2023Mental Health Champion awards ceremony and banquet was held on May 9th at the Capitol Plaza Hotel in Jefferson City. Three individuals were selected from statewide referrals as Mental Health Champions.

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

MICHAEL L. PARSON
GOVERNOR

Valerie Huhn
DIRECTOR

NORA K. BOCK
DIRECTOR
DIVISION OF
BEHAVIORAL HEALTH

STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH

1706 EAST ELM STREET
P.O. BOX 687
JEFFERSON CITY, MISSOURI 65102
(573) 751-4122
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June 7, 2023

Grants Management Officer
Office of Program Services, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Rd, Room 7-1091
Rockville, MD 20850

Dear Grants Management Officer:

The State Advisory Council for the Missouri Department of Mental Health, Division of Behavioral Health (DBH), has reviewed the state's FY2024 – 2025 Behavioral Health Block Grant State Plan – which combines plans for both mental health and substance use disorders. The State Advisory Council is committed to working with the DBH to create a well-integrated system of care that implements evidence-based practices and incorporates a focus on recovery. The State Advisory Council had many months to develop, review, discuss, and make recommendations regarding the Behavioral Health Block Grant State Plan. The Council met June 7, 2023, and voted to approve Missouri's final State Plan, written under our guidance.

We will continue to work with the DBH monitoring the implementation of the State Plan. We appreciate our involvement in the Block Grant planning development. We would like to express appreciation to SAMHSA for making these funds available.

Sincerely,

Derrick Green, Chair
State Advisory Council

Emily Stuckey, Vice Chair
State Advisory Council

State Advisory Councils for Division of Behavioral Health
Department of Mental Health
Meeting Minutes April 5, 2023

Members Present: Bryan Adams, Skyla Barlow, Kory Boustead, Cathi Bornhop, Cher Caudel, Kristin Davis, Derrick Green, Christa Harmon, Marsha Hawkins-Hourd, Cameo Jones, John Killian, Shane Laswell, Zachory Mallory, Missy McGaw, Tara McKinney, Michael Melion, Bobbi Jo Reed, Corey Reynolds, Greg Smith, Amber Stockreef, Emily Stuckey, Kelli Kemna

Members Absent: Angela Allphin, Michael Eanes, Lawrence Freeman, Lindsey Hammond, Tamera Kenny, Eric Martin, Mockia Shelton, Amye Trefethen, Jessica Vaughn

Department of Mental Health/Division of Behavioral Health (DMH/DBH) Staff: Rosie Anderson-Harper, Nora Bock, Jessica Bounds, Jeanette Simmons, James Busalacki, Shane Buscher, Edwin Cooper, Stephanie Dake, Natalie Erickson, Lori Franklin, Kortney Gentner, Michelle Gerstner, Connie Hardin, Leticia Heywood, Jennifer Johnson, Rachel Jones, Kateryna Kalugina, Jennifer Mihalevich, Casey Muckler, Brent Murphy, Angela Plunkett, Robert Reitz, Lisa Reynolds, Vicki Schollmeyer, Heather Senevey, Alex Withers, Christine Smith, Melvin Steele, , Michelle Sumner, Justin Tevie, Kate Wieberg, Karen Will, Doris Williams, Stacey Williams, Becky Wolken

Guests: Barb Scheidegger, Stacey Langendoerfer, Kim Crouch, Susan Depue, Jenny Armbruster

Topic/Issue	DISCUSSION	ACTION/PENDING RESPONSIBLE DUEDATE
Call To Order & Introductions	G. Smith called the meeting to order. L. Franklin requested attending members to send an email to A. Withers to record their attendance.	
Approval of minutes	G. Smith called for the approval of minutes. C. Harmon motioned to accept the minutes. B.J. Reed seconded the motion. Minutes approved as written.	
Division Director Update	N. Bock gave the Director's update. We have three pieces of legislation that we are putting forward. The first one looks really good. We are proposing to revise Missouri state statute for jail-based competency restoration or for those on bond, to a community based restoration. What this will do is help the department reduce our waiting list for those that are in jail waiting to get treatment at our facilities but for staffing and capacity reasons we cannot serve them. The second one looks ok for us. It is to remove references to the position title of Mental Health Coordinators. We quit funding that in 2009. We want to add Community Behavioral Health Liaisons (CBHL). The third one we just started working on and that is to revise the statue that will	

	remove the requirement for all individuals who are determined to be incompetent to stand trial. Nora also gave another update from the new report from St. Louis overdose data from MIMH. The overall drug related suicide deaths in 2022 has decreased by 9%. This is the first year since 2011 that they have decreased from the previous year. MIMH posted these findings on the opioid list serve, opioidstr@simplelists.com. Nora encouraged everyone to join that group.	
Budget	V. Schollmeyer gave the budget update. She highlighted areas and the budget report will be sent out to all SAC members to review. She shared the changes with supplemental funding which is to finish out the current FY23.	
Children's Service Update	A. Stockreef gave the Children's Services update on behalf of Cla Stearns. They are working on three pillars in the children's office, Education, Innovation and Collaboration, with a focus on educating individuals on best practices. They are working on dual diagnosis services for individuals that have both developmental disabilities and behavioral health needs. They have been collaborating with Department of Elementary and Secondary Education (DESE) on increasing mental health resources in schools.	
Guest Speakers	G. Smith introduced Jessica Bounds, DBH Director of Community Treatment Programming. She gave a presentation on SAMSHA BG Plan – DBH System of Services. **Mental Health and Substance Use Block Grants FY 2024-2025** G. Smith introduced Leslie Bradley, Program Coordinator and Donna Siebeneck, Director of Medicaid and Reimbursement, Department of Mental Health. They shared a presentation on DD Health Home & Inclusion of Patients with MHS/SUD Conditions. **Developmental Disabilities Health Home Presentation**	
Reports and Announcements	Missouri Credentialing Board: S. Langendoerfer provided the update. She said that the spring renewal is going on right now. The MARS training kicked off and they will have another one coming in July. There will be a Family Support Provider (FSP) training coming up at the end of April. There are currently 1395 CPSs, 41 CRPRs, 52 FSPs, and 9 YPSs credentialed. The MCB recently trained a few more Youth Peer Specialist trainers.	

Sub-Committees Update	Missouri P & A: No update given. NAMI: No update given. MO Families 4 Families: B. Scheidegger provided the update. She shared they are getting ready for Children's Mental Health Week which is May 7-13, 2023. They created posters to hand out to the communities. Missouri Behavioral Health Council: N. Lee provided the update. She shared that they have some conferences coming up. The Missouri Children Trauma Network, MOCTN Conference, May 2-3. Missouri Suicide Prevention, MSPN Conference, July 20th. They will have the Missouri Behavioral Health Council, MBHC Conference on September 20-22. They have hired two more individuals that will be part of Natalie Cook's team. They now have a monthly MBHC newsletter that they send out to providers and anyone who would like to receive it. DBH Prevention: A. Baker provided the update. She shared that DMH and the Department of Health and Senior Services (DHSS) collaborated on the new law that passed legalizing recreational marijuana. They are both on the same page on the affect that recreational marijuana has on your body, health, and mental health. They will continue to educate individuals on that. On April 19th they are having a prevention resources center meeting which will provide information to the communities regarding the effects of recreational marijuana. The prevention conference will be coming up in November 2023 in Columbia, Missouri. Children and Families Education: No update given Outcomes: The white paper on marijuana use has been completed and submitted. The group will continue to keep marijuana and prevention efforts on the radar. A new focus for this group will be on DBT; how many providers offer it, how many people served, and effectiveness rates. Membership: S. Gilkey and Z. Mallory have resigned from the SAC. Two (2) vacancies on the MHS and MHS Vice-Chair. Nominations for MHS Vice-Chair requested and membership applications will be reviewed today.	

	Executive: Meeting expectations reviewed and suggested change in location for the Aug. 2nd meeting/tour the Nixon Forensic Center. Public Relations: Need to formalize a purpose statement for this group. Substance Use Prevention & Recovery (SUPR) SAC Session: The group discussed the Opioid Settlement and potential projects to fund. Mental Health Services (MHS) SAC Session: The group discussed topics of interest such as DBT, Trauma-Informed Care, and Family Support Providers. G. Smith called the meeting adjourned.	
Next Meeting	Next meeting will be June 7, 2023	

State Advisory Councils for Division of Behavioral Health
Department of Mental Health
Meeting Minutes June 7, 2023

Members Present: Angela Allphin, Lisa Cain, Cher Caudel, Kristin Davis, Derrick Green, Christa Harmon, Kelli Kemna, Tamera Kenny, John Killian, Michael Melion, Amber Stockreef, Emily Stuckey, Amye Trefethen

Members Absent: Bryan Adams, Jenny Armbruster, Skyla Barlow, Kory Boustead, Cathi Bornhop, Michael Eanes, Lawrence Freeman, Lindsey Hammond, Marsha Hawkins-Hourd, Cameo Jones, Shane Laswell, Corey Reynolds, Eric Martin, Missy McGraw, Tara McKinney, Bobbi Jo Reed, Mockia Shelton, Gregory Smith

Department of Mental Health/Division of Behavioral Health (DMH/DBH) Staff: Rosie Anderson-Harper, Nora Bock, Jessica Bounds, Jeanette Simmons, James Busalacki, Shane Buscher, Edwin Cooper, Stephanie Dake, Natalie Erickson, Lori Franklin, Kortney Gentner, Michelle Gerstner, Connie Hardin, Leticia Heywood, Jennifer Johnson, Rachel Jones, Kateryna Kalugina, Jennifer Mihalevich, Casey Muckler, Brent Murphy, Angela Plunkett, Robert Reitz, Lisa Reynolds, Vicki Schollmeyer, Heather Senevey, Alex Withers, Christine Smith, Melvin Steele, Michelle Sumner, Justin Tevie, Kate Wieberg, Karen Will, Doris Williams, Becky Wolken

Guests: Barb Scheidegger, Nichole Dawsey, Laura Bruce, Elizabeth Standford

Topic/Issue	DISCUSSION	ACTION/PENDING RESPONSIBLE DUEDATE
Call To Order & Introductions	D. Green called the meeting to order. New members, Lisa Cain and Jenny Armbruster on behalf of Nichole Dawsey introduced. L. Franklin requested attending members to send an email to A. Withers to record their attendance.	
Approval of minutes	D. Green called for the approval of minutes. C. Caudel motioned to accept the minutes. E. Stuckey seconded the motion. Minutes approved as written.	
Division Director Update	N. Bock gave the Director's update. She recognized SAC member, Amye Trefethen, as she received the Mental Health Champion Award. N. Bock spoke about the budget; many items requested were approved and some that we did not request, were approved. Overall, it was a very good year for the budget. Division of Behavioral Health, (DBH) is a $1.6 billion organization. Department of Mental Health (DMH) is a $4 billion organization. The vacancy rates are still up regarding workforce. Psychiatrists are at a 50% vacancy rate, Psychologist are at a 40% vacancy rate, and LPNs are at a 42 % vacancy rate. Since the launch of 988 in July of 2022, the 988 team has been working hard. She reported	

	that right now, Missouri consistently ranks in the top 10 among all states in the U.S. territories for our in-state answer rate. April 2023 was the best in-state answer rate for Missouri. It increased by 2% since last month which makes Missouri at 93%. The number of calls answered in state were around 4300. There is also a text and chat feature. Text in the month of April was at 817 and chats were at 2200.	
Budget	V. Schollmeyer gave the budget update. She gave an update of the new items since the last meeting and emailed out a full budget summary to the SAC members.	
Children's Service Update	Amber Stockreef gave the Children's Services update on behalf of Cla Stearns. They have a proposal to develop a children's waiver, they are waiting on the budget approval. The children's waver is an 11-15 c demonstration waiver. The waiver shows that we have to implement services and actually show an outcome at the end. We will be collecting data on this and seeing how children are supported based on services.	
Guest Speaker	D. Green introduced Lauren Spartz, ReDiscover, Program Coordinator, School Based Services. She gave a presentation on School Based Services in Eastern Jackson County. ReDiscover School-Based Services | dmh.mo.gov	
Reports and Announcements	Missouri Credentialing Board: S. Langendoerfer provided the update. They have hired two (2) new staff members. They are working on spring renewal wrap ups. The Medication Assisted Recovery Specialist (MARS) training was just rolled out this month and moving forward the training will be self-paced so individuals have the opportunity take that at any time. Missouri P & A: No update given. NAMI: A. Trefethen provided the update. She said that there is a new peer course that is in person that will be in Jefferson City starting on July 5th. It is through Landmark Recovery Center and it will be free. They have a NAMI Home Front Teacher training in July, which is a training for family members of people who are in the service or veterans who live with mental health disorders. MO Families 4 Families: No update given.	

Sub-Committees Update	MO Behavioral Health Council: No update given. Children and Families Education: No update given. Outcomes: M. Melion provided the update. The outcomes committee submitted white paper for legalization of marijuana in Missouri. After further review there are multiple agencies researching, tracking and providing education on the use of legalized marijuana and its effects on various components in correlation to recreational use. The group will shift focus to DBT. Membership: D. Green shared that one (1) new membership application had been received. It will be reviewed by the subcommittee. Executive: D. Green announced Cher Caudel as the new MHS Vice-Chair. The August 2nd SAC meeting will be held at Fulton State Hospital (FSH) and will include a facility tour. The DMH SAMHSA Block Grant Plan was discussed. A. Trefethen motioned to accept, M. Melion seconded, Plan was approved as presented, SAMHSA Block Grant letter approved and signed. Public Relations: E. Stuckey provided the update. She shared that they have decided on their mission statement. The public relations subcommittee will be informing and educating community members on the finances and actions of the State Advisory Council with the ultimate goal of facilitating staff members, recruiting new staff members and increasing community involvement and understanding of why behavioral health needs and concerns are important. The SAC committee took a vote to approve the mission statement. A. Stockreef motion to approve mission statement. D. Green seconded. **Substance Use Prevention & Recovery (SUPR) SAC Session & Mental Health Services (MHS) SAC Session:** The SUPR and MHS groups combined for the afternoon session. They reviewed the mission and purpose of SAC and then focused on the Opioid Settlement dollars. Discussions were had around, how will the funds be used by others/groups, processes in place for oversite of the spending, transparency of the spending, what do other states (CO and MT) have in place for transparency, i.e. a dashboard.	

Next Meeting	D. Green called the meeting adjourned. Next meeting will be August 2, 2023	

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.
State Medicaid Agency

Start Year: 2024 End Year: 2025

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Bryan Adams	Family Members of Individuals in Recovery (to include family members of adults with SMI)		22933 US 61 Eolia MO, 63344 PH: 573-375-4866	Bryan.Adams@aviaryrc.com
Angela Allphin	Persons in recovery from or providing treatment for or advocating for SUD services		600 W. Morrison Fayette MO, 65248 PH: 660-537-3537	angi@crossroadscounselingllc.org
Jenny Armbruster	Persons in recovery from or providing treatment for or advocating for SUD services	PreventEd	9355 Olive Blvd St Louis MO, 63132 PH: 314-368-9635	jarmbruster@prevented.org
Skyla Barlow	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		2125 W Aventura Way St Louis MO, 63134	Sbar4421@gmail.com
Darla Belflower	Persons in recovery from or providing treatment for or advocating for SUD services	Swope Health Services	12204 E 40th Street S Independence MO, 64052 PH: 816-517-1499	d.belflower@yahoo.com
Cathi Bornhop	Parents of children with SED		2761 Providence Ridge Dr Wentzville MO, 63385	Cathib212@icloud.com
Kory Boustead	Family Members of Individuals in Recovery (to include family members of adults with SMI)		408 Deer Valley Court Jefferson City MO, 65109 PH: 573-462-0190	koryboustead@gmail.com
Lisa Cain	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		205 East Main Washington MO, 63090 PH: 314-795-2305	cetacain@yahoo.com
Cher Caudel	Others (Advocates who are not State employees or providers)	Public Administrator of Moniteau County	200 E Main Street California MO, 65108 PH: 573-796-4704	moniteaucopa@gmail.com
Kristin Davis	State Employees	Missouri Department of Health and Senior Services	912 Wildwood Drive Jefferson City MO, 65109 PH: 573-526-4389	kristin.davis@health.mo.gov

Michael Eanes	Persons in recovery from or providing treatment for or advocating for SUD services		3201 Martha Drive Columbia MO, 65202 PH: 573-607-0801	meanes@connectionstosuccess.org
Bryant Fogelbach	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		2638 Highway 109 Wildwood MO, 63030 PH: 636-575-2022	Semperfi602@gmail.com
Derrick Green	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		3618 W Maplewood Street Springfield MO, 65807 PH: 517-425-8711	Derrickjgreen@gmail.com
Christa Harmon	Persons in recovery from or providing treatment for or advocating for SUD services		PO Box 116 Sullivan MO, 63080 PH: 573-259-2814	mrsmooch73@gmail.com
Marsha Hawkins -Hourd	Persons in recovery from or providing treatment for or advocating for SUD services	Child & Family Empowerment	7036 Camden Court St Louis MO, 63160 PH: 314-662-0953	Mhourd.tcu@gmail.com
Cameo Jones	Persons in recovery from or providing treatment for or advocating for SUD services	LIV Recovery Sober Living	719 Stonewood Bend Lake St Louis MO, 63367 PH: 573-514-2128	cjones@livsoberliving.com
Kelli Kemna	State Employees	Missouri Dept of Mental Health/Housing	1706 E Elm Street Jefferson City MO, 65101 PH: 573-522-6519	Kelli.Kemna@dmh.mo.gov
Tamara Kenny	Others (Advocates who are not State employees or providers)	Missouri Protection & Advocacy	925 S Country Club Dr Jefferson City MO, 65109 PH: 314-390-1595	tamara.kenny@mo-pa.org
John Killian	Others (Advocates who are not State employees or providers)	Jackson County Public Administrator	415 East 12th Street Kansas City MO, 64106 PH: 816-517-7585	Jkillian@jacksongov.org
Shane Laswell	Persons in recovery from or providing treatment for or advocating for SUD services		8023 Oakfield Drive O'Fallon MO, 63368 PH: 636-561-5680	shane.laswell@reclaiminghope-mo.org
Eric Martin	State Employees	Missouri Dept of Social Services/Medicaid	615 Howerton Jefferson City MO, 65109 PH: 573-522-8336	Eric.D.Martin@dss.mo.gov
Lisa Martin	Persons in recovery from or providing treatment for or advocating for SUD services		1718 Sylvan Drive Poplar Bluff MO, 63901	lisamartin@mohigh.org
Tara McKinney	Persons in recovery from or providing treatment for or advocating for SUD services		930 Wildwood Drive Jefferson City MO, 65109	tara.mckinney@health.mo.gov
Michael Melion	State Employees	Missouri Department of Corrections	2715 Plaza Drive Jefferson City MO, 65109 PH: 573-526-5285	Michael.Melion@doc.mo.gov
Bobbi Jo Reed	Persons in recovery from or providing treatment for or advocating for SUD services		4505 St John Ave Kansas City MO, 64123 PH: 913-706-2222	reedbobbijo@gmail.com

Corey Reynolds	Family Members of Individuals in Recovery (to include family members of adults with SMI)		2080 Three Rivers Blvd Poplar Bluff MO, 63901 PH: 573-840-9631	creynolds@trcc.edu
Mockia Shelton	Persons in recovery from or providing treatment for or advocating for SUD services		2000 Gerald Park Lane St Louis MO, 63042 PH: 314-482-9037	Mockias1@gmail.com
Casey Spartz	Persons in recovery from or providing treatment for or advocating for SUD services	Heartland Center for Behavioral Change	1730 Prospect Ave Kansas City MO, 64127 PH: 816-377-5561	CSpartz@heartlandcbc.org
Amber Stockreef	State Employees	Missouri Department of Mental Health	1706 E. Elm Street Jefferson City MO, 65101 PH: 573-526-0350	Amber.Stockreef@dmh.mo.gov
Emily Stuckey	Persons in recovery from or providing treatment for or advocating for SUD services		11 Lockhaven Ct Lake St Louis MO, 63367 PH: 636-579-2276	emily.stuckey@thearchwayinstitute.org
Amye Trefethen	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		2114 Millbrook Ct Jefferson City MO, 65101 PH: 307-760-4995	amye@namimissouri.org

*Council members should be listed only once by type of membership and Agency/organization represented.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

The state employee position that serves as representative from Missouri Department of Elementary and Secondary Education/Vocational Rehabilitation is currently vacant and will be filled once the position is filled.

Bryant Fogelbach is a Veteran.

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2024 End Year: 2025

Type of Membership	Number	Percentage of Total Membership
Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	5	
Family Members of Individuals in Recovery (to include family members of adults with SMI)	3	
Parents of children with SED	1	
Vacancies (individual & family members)	0	
Others (Advocates who are not State employees or providers)	3	
Total Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services), Family Members and Others	**12**	**66.67%**
State Employees	5	
Providers	0	
Vacancies	1	
Total State Employees & Providers	**6**	**33.33%**
Individuals/Family Members from Diverse Racial and Ethnic Populations	6	
Individuals/Family Members from LGBTQI+ Populations	3	
Persons in recovery from or providing treatment for or advocating for SUD services	14	
Representatives from Federally Recognized Tribes	0	
Youth/adolescent representative (or member from an organization serving young people)	0	
Total Membership (Should count all members of the council)	**18**	

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

The State Advisory Council to the Missouri Department of Mental Health is an integrated advisory council includes representatives not only with personal and/or familial experience with mental illness but also of personal and/or familial experience with substance use disorders. The integration of these two councils was completed several years ago with the assistance of SAMHSA. The members of the council that are reported at the bottom of this page as "Persons in recovery from or providing treatment for or advocating for SUD services" are full members of the State Advisory Council in the same manner that those listed as "Total Individuals in Recovery, Family Members & Others" are members of the State Advisory Council. Their perspective, experiences and input are valued in the same manner as those representing SMI/SED. The "Total Membership (should count all members of the council)" as was automatically calculated in the table above is inaccurate. Missouri has a total of 31 members on the State Advisory Council with the only vacancy representing the state employee representative of the Department of Elementary and Secondary Education/Vocational Rehabilitation.

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? (●) Yes ( ) No

b) Posting of the plan on the web for public comment? (●) Yes ( ) No

If yes, provide URL:

https://dmh.mo.gov/behavioral-health/block-grant

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

https://dmh.mo.gov/behavioral-health/block-grant

c) Other (e.g. public service announcements, print media) ( ) Yes (●) No

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

23. Syringe Services Program (SSP) - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction[1,2] on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the **Consolidated Appropriations Act**, 2018 (P.L. 115-141) signed by President Trump on March 23, 2018[3].

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers[4]. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs[5]: These documents can be found on the Hiv.gov website: **https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs**,

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy **https://www.samhsa.gov/sites/default/files/grants/ssp-guidance-for-hiv-grants.pdf ,**

2. **Centers for Disease Control and Prevention (CDC)Program Guidance for Implementing Certain Components of Syringe ServicesPrograms,2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention **http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf,**

3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs** **http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf ,**

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
  - Include proposed protocols, timeline for implementation, and overall budget
  - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

End Notes

[1] Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds ***only*** and is consistent with guidance issued by SAMHSA.

[2] Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C.§ 300x-31(a)(1)(F)) and 45 CFR § 96.135(a)(6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

[3] Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

[4] Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

[5]***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a **description of the elements of an SSP** that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and

HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

As of September 20, 2019, Missouri has a determination of need in place. Missouri does not fund a Syringe Services Program with SABG funds.

Environmental Factors and Plan

Syringe Services Program (SSP) Information – Table A - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Dollar Amount of SUBG Funds to be Expended for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone Provider (Yes or No)
No Data Available					

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Missouri does not fund a Syringe Services Program with SABG funds.

MHBG BSCA Supplemental Funding Plan

Bipartisan Safer Communities Act (BSCA) (P.L. 117-159), 2022
Intended start/end date: September 29, 2023 – September 30, 2025
Amount: $1,088,755

Background

The Missouri Department of Mental Health (DMH) is made up of two major program divisions:

- Behavioral Health (DBH)
- Developmental Disabilities (DD)

DMH directly operates inpatient and habilitation facilities for BH and DD, respectively. DMH serves more than 170,000 Missourians with mental illness, developmental disabilities, and substance use disorders. It is a safety net for the state's most vulnerable citizens and their families. Approximately 99% of DMH's 170,000 consumers receive their services through local contracted community-based provider agencies. The DMH mission is:

- Prevention: Reduce the prevalence of mental disorders, developmental disabilities, and substance use disorders.
- Treatment: Operate, fund, and license or certify modern treatment and habilitation programs provided in the least restrictive environment.
- Improve Public Understanding: Improve public understanding and attitudes toward individuals with mental illness, developmental disabilities, and substance use disorders.

Community behavioral health services are delivered through the DMH network of contractual service providers. DBH establishes standards and requirements for delivery of community-based behavioral health services through contracts with its local community mental health centers (CMHCs)/certified community behavioral health organizations (CCBHOs) are designated as the lead agencies for all community-based psychiatric services, as authorized by state statute. Designated service areas by county assure statewide availability of services; allocated funding to the CMHCs/CCBHOs are contractually obligated to BH-designated target populations of:

- Adults with serious mental illnesses as specified by diagnosis and functional abilities;
- Children with serious emotional disturbances as specified by diagnosis and functional scales;
- Individuals with forensic commitments to DMH.

DMH is experienced in disaster response and is known as an innovator and leader in the field of disaster behavioral health. The Missouri Behavioral Health Council (MBHC) (https://www.mobhc.org/) is the provider association and represents these lead agencies utilized in response to disasters in Missouri. A map of CCBHOs by county can be found at https://dmh.mo.gov/mental-illness/help/community-mental-health-centers.

Despite Missouri's reputation for innovation, we do not have the programmatic, technological, human resources or fiscal support/infrastructure or funding to address disasters. Missouri is a fiscally sound and prudent state. Services for persons impacted by trauma, crisis and other disasters rely largely on federal funding and technical assistance. The already taxed public mental health system has no additional or predictable capacity to accommodate the unique community outreach model and challenging needs in our communities without additional assistance.

In addition, a school shooting occurred just one year ago in the St. Louis area, and the community is dealing with repetitive trauma from other events that continue to layer upon the taxed system. The St. Louis area remains one of the hardest hit from the pandemic and past disaster events to include flooding, the death of Michael Brown/Ferguson, the Coldwater Creek radioactive material and the most recent school shooting.

We also know that behavioral health issues have been exacerbated during the pandemic, especially among young adults. In 2021, suicide was among the top 9 leading causes of death for people ages 10-64 and the second leading cause of death for people ages 10-14 and 20-34, according to the CDC. That same year, Missouri's suicide rate was 19.1 per 100,000 residents, with more than 1,174 Missourians dying by suicide. As the largest national suicide prevention services, the 988 Suicide & Crisis Lifeline offers in-the-moment crisis support for anyone experiencing a mental health, suicide, or substance use crisis.

Crisis Set Aside

DMH, behavioral health providers, and community partners have been working diligently to establish a comprehensive "no-wrong-door" integrated crisis response system with the 988 at its core. According to data provided by Vibrant Emotional Health on 988 volume, Missouri 988 centers have answered 46,647 calls. This represents a 65% increase in call volume from June of 2022 to 2023. Missouri's in-state call answer rate since the national launch is 91%. The significant increase in volume highlights the growing demand for crisis services in Missouri. This underscores the need for expansion of behavioral health crisis services to ensure that Missouri's crisis response continues to meet the needs of individuals in crisis. By investing in the expansion of crisis services, Missouri will be well-positioned to further enhance access to timely and effective support to those reaching out, including those experiencing a suicide crisis.

Item to be funded:

1.0 FTE Disaster and Crisis Response Liaison to coordinate crisis response and emergency preparedness plans and implementation. The FTE is shared by the Division of Behavioral Health and Office of Disaster Services (ODS). This temporary position is classified as a Senior Program Specialist with a working title of Disaster and Crisis Response Liaison with .5 FTE being responsible for the coordination of all items listed in the Disaster Services request. The individual works alongside the other ODS staff and reports to the Director of Disaster Services. In addition, this position works alongside crisis services staff within the DBH to coordinate and integrate crisis services within ODS. This position is co-supervised by the Director of Disaster Services and the DBH Crisis Services Coordinator. The Disaster and Crisis Response Liaison collaborates with crisis response and behavioral health providers to enhance the Behavioral Health Strike Team (BHST) and emergency preparedness plans to ensure providers have the capacity they need to respond to natural and human-caused disasters or other type of traumatic event. This would include the coordination of activities between DBH, DD, 988 centers, mobile crisis response providers, behavioral health providers, and other emergency response providers, including emergency managers. **$112,980** (includes salary, fringe, indirect).

First Episode Psychosis Set Aside

DMH sees the value in prioritizing early intervention for individuals experiencing their First Episode of Psychosis (FEP). Set aside funding will be used to contract for 1.0 FTE at MBHC to develop the workforce with an emphasis on first episode psychosis. By equipping the community behavioral health workforce with evidence-based practices for this population, DMH will promote enhanced clinical expertise embedded broadly within community based services, realize more positive life outcomes for individuals and families experiencing psychosis, and potentially demonstrate healthcare savings through reduced emergency room use and hospital admissions. Set Aside funding will also be used to support ongoing improvements within the community behavioral health workforce by providing select evidence based

training and/or evidence informed educational opportunities that highlight first episode care and the importance of early identification and intervention.

Items to be funded:

- FTE at MBHC to develop the workforce with an emphasis on First Episode Psychosis. **$108,876**

1. **Describe any plans to utilize the BSCA supplemental funds to develop/enhance components of your state's mental health emergency preparedness and response plan that addresses behavioral health. Please include in your discussion how you plan to coordinate with other state and federal agencies to leverage crisis/mental health emergency related resources.**

DMH will collaborate with crisis contact centers (988 and local hotlines) and mobile crisis response providers to develop a statewide behavioral health crisis response and emergency preparedness plan to ensure crisis contact centers and crisis response providers have the capacity they need to respond to sudden and large spikes in call, text, or chat volume as well as spikes in mobile crisis response following a public service announcement, disaster, or other type of traumatic event. This will include coordinating with ODS and other emergency response providers, including 911/law enforcement.

The combination of exposure to trauma, demanding schedules, and physically challenging roles puts first responders at risk for mental health issues such as depression, post-traumatic stress, suicidal behaviors, and reduces their ability to respond effectively to those in the community who are in crisis. Missouri has recently passed legislation to assist first responders get mental health treatment and DMH has formed the following partnerships to provide first responder assistance:

- Missouri State Highway Patrol (MSHP)
    - Critical Incident Stress Management (CISM) training – DMH has partnered with MSHP to conduct comprehensive, integrated, systematic, and multi-component trainings designed to assist employees involved in a traumatic and/or critical event to return to or maintain an effective level of functioning. CISM may include a combination of assistance services to include individual or group debriefing after a critical incident.
    - Post Critical Incident Seminars (PCIS) – DMH has partnered with MSHP to conduct multiple PCIS sessions. PCIS targets first responders who experience a critical incident and is led by CISM trained peer team members. PCIS is a three-day event and funding allows at least 35 first responders and their significant other to attend at no cost. The goal of PCIS is to provide interpersonal support, education, therapy, and resources to address trauma experienced by first responders.
- Missouri Department of Corrections (DOC)
    - CISM – DMH has partnered with DOC to provide CISM training (similar to MSHP partnership described above).
    - PCIS – DMH has partnered with DOC to provide PCIS sessions for correctional officers and probation officers (similar to MSHP partnership described above).

Item to be funded:

- Disaster and Crisis Response Liaison (previously described above) to coordinate crisis response and emergency preparedness plans and implementation. **$112,980** (includes salary, fringe, indirect)
- MSHP has dedicated funding to support two PCIS events per year, but there is always a waitlist of first responders for PCIS. Funds will be utilized to add an additional MSHP PCIS session to serve

additional first responders and their spouses. A small portion of funds ($5,000 or less) will go to supplies for the PCIS event. **$35,000**

- Two CISM trainings will be conducted. The first CISM training will be specific to DOC staff and second training will target first responders and include new CIT regional coordinators. **$18,900**

2. Describe any plans to utilize the BSCA supplemental funds to develop/enhance a state behavioral health team that coordinates, provides guidance, and gives direction in collaboration with state emergency management planners during a crisis.

ODS continues to enhance the state disaster BHST that responds to critical events in the state. The intent and purpose of the BHST is to quickly deploy trained individuals from a CMHC/CCBHO or other behavioral health provider and the ODS and establish communications with the impacted region/county/city/facility to determine the level of trauma and develop a strategy to deliver psychological first aid to survivors and first responders.

ODS and the CMHC/CCBHO have spent the last year enhancing the concept of operations to allow for better response to citizens impacted by natural and human caused disasters. The BHST provides behavioral health support to survivors, responders, and other disaster workers. Additionally, the BHST works directly with other state agencies to coordinate other state or federal assistance, if needed.

During the pandemic, half of the BHST membership was lost due to retirement and attrition. Over the last year, we have been able to recruit to get new members and have added additional membership to the team. This continued funding enables work to continue on expanding the team through several avenues. The funding request would allow staff to travel to conferences to present and exhibit on the BHST (to include conference and travel fees) and to create culturally appropriate promotional materials to explain what the BHST is, how to request it, and recruit new members. This amount would also allow us to develop other promotional materials to be used by the BHST members to help distinguish who they are upon deployment.

The BHST has responded to several mass casualty events in Missouri over the last several years to include the Branson Duck Boat accident, an Amtrak train derailment, and a school shooting in St. Louis. Through these deployments, DMH has found that localized and smaller responses is where the BHST is more successful. The larger scale events, like the school shooting, showed us that a larger number of BHST members are needed as it was a struggle to keep up with the demand on the behavioral health system. This funding will assist the state in enhancing the BHST's training and education in preparation to deploy for future events around the state through training with subject matter experts in suicide prevention and trauma from around the country.

In addition, the state has previously held a shortened summit to train BHST on various subjects. This funding will allow DMH ODS to expand this to be a more specialized training for BHST members by hosting the first two-day conference designed solely for the BHST members. During this training, DMH ODS will bring in subject matter experts to educate and prepare the BHST members on various types of responses like mass violence and other mass casualty events that may happen in the community. This will assist the BHST to be better prepared when something happens. In addition, this conference would allow for a tabletop exercise to be completed to test the information learned during the conference and other trainings in order to identify gaps and lessons learned before future responses.

Bipartisan Safer Communities Act (BSCA) (P.L. 117-159), 2022
Intended start/end date: September 29, 2023 – September 30, 2025
Amount: $1,088,755
Additional information on the Missouri BHST can be found at: https://dmh.mo.gov/disaster-services/behavioral-health-strike-team. The FTE, Disaster and Crisis Response Liaison, will assist with coordinating DBH crisis services with the BHST.

Items to be funded:

- Travel to conferences in MO to present and exhibit on the BHST. Development and delivery of promotional materials of varying types for the BHST to include brochures, videos, social media, and other promotional items. Development of vests and badging for the BHST. **$50,000**
- Specialized training is required for the BHST members which includes NOVA (National Organization for Victims Assistance): the basic course, Incident Command, and Psychological First Aid. BHST members are required to take two annual trainings on various topics around trauma. This includes subject matter experts' trainings. Total request for 1 Basic NOVA and 2 Advanced NOVA courses for a total of **$105,000**
- Development and launch of the first MO BHST disaster two-day conference. This will allow us to bring in subject matter experts, conference fees, lodging, meals, and speaker fees (to include travel expenses) for all BHST and ODS members. **$150,000**
- Development of online training courses for current and future BHST members on topics around trauma, disaster preparedness, emergency planning writing, how to include behavioral health in emergency plans, and other relevant topics. **$50,000**
- Provide suicide prevention/intervention training for crisis and other mental health emergency responders. **$20,000**

3. **Describe any plans to utilize the BSCA supplemental funds to develop/enhance a multidisciplinary mobile crisis team that can be deployed 24/7, anywhere in the state rapidly to address any crisis.**
DMH is currently enhancing the statewide mobile crisis response system. For crisis related disasters, the Disaster and Crisis Response Liaison, assists with coordinating DBH mobile crisis response services and facilitates state emergency response efforts to ensure timely and adequate response. DMH will also provide evidence-informed disaster/crisis debriefing training for emergency response providers including law enforcement, behavioral health providers and crisis centers.

The Missouri Crisis Intervention Team (MO CIT) program is a partnership with law enforcement and other first responders, behavioral health providers, hospitals, courts, individuals with lived experience, and community partners. The goal of CIT is to promote more effective law enforcement interactions with individuals in crisis, connect individuals in crisis with available resources, improve safety of the first responder and the individual in crisis, reduce stigma, and expand and sustain CIT across the state. There are 34 local CIT Councils and CIT officers in 110 of Missouri's 114 counties. The Missouri CIT program is known as a national leader in CIT and is recognized annually at the CIT International Conference for their first responder wellness programs. MO CIT will celebrate its 10 year anniversary at the 2024 CIT state conference which brings together 500-600 law enforcement, first responders, behavioral health, community stakeholders, and individuals with lived experience.

Mobile crisis response teams respond to an individual in crisis wherever the crisis is occurring, including at someone's home, workplace, school, or other community location. Mobile crisis response teams respond without law enforcement assistance wherever possible, however, there are times that mobile crisis response providers request a trained CIT officer respond to the situation depending on the acuity and situation of the crisis. There are also times that mobile crisis response will respond with a CIT officer

to offer adequate crisis intervention and de-escalation. This approach ensures that warm handoffs and connections to the most appropriate emergency response provider occurs and individuals receive the best care and support possible.

MO CIT has recently hired six regional coordinators who take direction from the MO CIT State Coordinator and assist the Training Coordinator as directed and promote/expand CIT across the state by following the Missouri Model of CIT. Regional coordinators also assist in first responder wellness and coordinate first responder debriefings for critical incidents that occur in their region.

The First Responder Provider Network (FRPN) is a network of trained behavioral health professionals identified by MO CIT who specialize in helping first responders struggling with depression, anxiety, relationships, post-traumatic stress symptoms, and more. These providers understand the unique professional culture and are and vetted by first responders. There are currently 50 clinicians participating in the FRPN and their contact information can easily be accessed on the MO CIT Law Enforcement Wellness App.

MO CIT is a critical component of the Missouri behavioral health crisis response system, as law enforcement involvement is sometimes necessary for proper response during a behavioral health crisis. The MO CIT is a robust program that prioritizes training of law enforcement officers to ensure the best possible outcome for an individual in crisis. The additional funding to support MO CIT and the FRPN will enhance the program infrastructure and support the collaboration and education of crisis trained law enforcement.

Item to be funded:

- Disaster and Crisis Response Liaison (previously described) to coordinate crisis response and emergency preparedness plans and implementation. **$112,980** (includes salary, fringe, indirect)
- The CIT 10th annual conference to highlight the accomplishments of CIT and enhance partnerships and collaboration with first responders in Missouri. **$73,500**
- Administrative support for the FRPN to include meetings to promote collaboration, provide education, and formalize the network. **$7,000**

4. **Describe any plans to utilize the BSCA supplemental funds to develop/enhance crisis/mental health emergency services specifically for young adults, youth and children, or their families, including those with justice involvement and having SED/serious mental illness (SMI).**

DMH has explored the implementation of a youth/young adult specific mobile crisis response team pilot over the past year. DMH has determined that mobile crisis response services should be available and well-equipped to provide community-based crisis intervention to any Missourian regardless of age. DMH is, however, prioritizing additional training for mobile crisis response providers on responding to youth and young adults in crisis. In addition, DMH is enhancing crisis service promotion efforts to ensure all Missourians, including youth, young adults, and their families are aware of the services available throughout the state. This funding will assist in creating promotional materials to enhance public awareness and education of behavioral health crisis and mental health emergency services. The Disaster and Crisis Response Liaison will assist with the coordination of youth and young-adult focused mobile crisis response training and the development and dissemination of crisis and mental health emergency

service promotional materials to increase awareness and provide information about available services and supports.

Item to be funded:

- Youth/Young Adult Focused Mobile Crisis Response Training. **$20,000**
- Behavioral Health Crisis & Mental Health Emergency Service Promotional Materials. **$122,375**
- Disaster and Crisis Response Liaison to coordinate the development and dissemination of promotional materials regarding behavioral health and mental health emergency resources. **$112,980** each year; includes salary, fringe, indirect.

5. **Describe any plans to utilize the BSCA supplemental funds to develop/enhance services provided to communities that are affected by trauma and mass shootings/school violence.**

The American Psychological Association (APA) indicates that the regularity of which the US is seeing mass shootings is impacting mental health; creating stress and "dulling compassion" that cause concern and demonstrate the need for change. Missouri has most recently seen a school shooting on October 24, 2022, where the gunman had around 600 rounds of ammunition in the school. He was shot and killed by police inside the school. Before he was killed, he killed two people – a student and a teacher – and injured many others. An APA article shows that more kids are expressing they are afraid of what might happen at their school. Those concerns have been linked to elevated anxiety levels and fear. The stress is "embedded within the context of the pandemic, economic challenges, political polarization, climate-related disasters, and other factors..." This is seen as a "cascade of collective traumas." It is known that for witnesses and survivors the suffering can be severe. Studies have shown that there are increases of mental health disorders and other conditions after a mass shooting. https://www.apa.org/monitor/2022/09/news-mass-shootings-collective-traumas

Recovery for individuals and communities from mass violence can take years and can have a very negative impact on communities. Taking into consideration the layers of trauma already embedded in our communities from natural disasters like flooding and tornados along with human-caused disasters of school shootings, gun violence, weapons/threats on campus, and what we continue to see from COVID, we know that additional resources are needed to support the community.

A lesson learned from other mass violence events, including the St. Louis school shooting, is the need for support in schools for planning for various crisis events before the event happens. Many schools bring in trainers for PREPaRE *after* a school shooting to work on recovery. The DMH ODS is partnering with Burrell Behavioral Health Center, who is the only behavioral health agency in MO to have trainers for the PREPaRE model, to bring this training to education communities across MO. This funding will allow us to bring additional PREPaRE trainings to areas in MO *before* tragedy strikes. https://www.nasponline.org/professional-development/prepare-training-curriculum/about-prepare

In addition, this funding will allow us to expand mass violence resources and TeachWell for educators across MO. TeachWell was developed in response to the St. Louis, MO school shooting. TeachWell was designed after 32 schools (outside of where the shooting happened) in the St Louis school district expressed an increase in need for support for their educators and students around wellness and mental health. In addition, we have had several schools around the state reach out for support after threats of mass violence have been made at their local schools. DMH ODS has worked with Learfield, a media and marketing agency, to develop and promote mass violence resources for educators and communities after

mass violence events. This funding will allow DMH ODS to continue to address mass violence by developing, enhancing, and sharing digital and social content in affected areas and promoting help for affected Missourians including teenagers, young adults, parents, influencers, teachers and other educators, and first responders.

DMH supports residents dealing with these incidents, acknowledging the normality of emotional distress such as anxiety and sleep troubles. A beacon of hope shines through the offer of free, confidential support via calls, texts, or chats to the crisis hotline 988, connecting individuals with trained counselors. Local resources stand ready to aid Missourians with counseling services and education. The plan comprises three goals: elevating help-seeking through 988 engagements, fostering professional education through trauma-informed videos, first responder educational series and TeachWell wellness for educators. DMH will direct individuals to valuable resources by boosting web traffic.

Items to be funded:

- PREPaRE trainings to be offered to educational entities and behavioral health providers throughout MO. **$12,000**
- TeachWell and Mass Violence campaign. **$50,000**
- Content Hub for all projects developed to be utilized and promoted around the state. **$12,000**

6. **Describe any plans to utilize the BSCA supplemental funds to develop/enhance culturally and linguistically tailored messaging to provide information about behavioral health in a crisis/mental health emergency and/or to identify culturally/linguistically appropriate supports for diverse populations.**

The Disaster and Crisis Response Liaison is assisting with the development of culturally and linguistically tailored messaging to provide information about behavioral health in a crisis/mental health emergency and/or to identify culturally/linguistically appropriate supports for diverse populations. Over the past year, DMH has collaborated with the Missouri Office of Refugee Administration and others to gather insight into what materials may be most useful in different languages and representative of different cultural considerations. Through a series of committee discussions, DMH has gathered feedback on the cultures and languages spoken by Missouri's high risk populations and is developing materials that reflect this information. Through these discussions, the need for increased funding to support these efforts was identified as information regarding other crisis response services is pertinent to share concurrently. This continued and increased funding enables work to continue on enhancing access to behavioral health crisis services for all Missourians.

Items to be funded:

- Disaster and Crisis Response Liaison to coordinate the development and dissemination of culturally/linguistically appropriate educational materials. **$112,980** (includes salary, fringe, indirect)
- Develop and disseminate culturally/linguistically appropriate educational materials. **$71,124**

7. **What other mental health emergency/crisis behavioral health practices or activities does the state plan to develop or enhance using the BSCA supplemental funds?**

The Victim Information Center (VIC) is a centralized location designated after a mass casualty event intended to support victim identification. At the VIC, family members can obtain information on the status of the event, provide identifying information about the victims, receive death notifications, and obtain

emotional care and other supportive services. Behavioral health team members are assigned different duties depending on their licensed status within the VIC.

A VIC would be stood up at the direction of the Missouri State Emergency Management Agency (SEMA) following a disaster occurring in or impacting the state, resulting in multiple fatalities, injuries and/or missing persons. The VIC is coordinated by local, state, and federal response agencies including health, emergency management, and Coroner/Medical Examiners.

The VIC is a component of fatality operations and deployed when requested locally. VIC and morgue operations are coordinated through the Missouri Mortuary Operations Response Team (MO MORT-1), the state's fatality management team. ODS coordinates, facilitates and runs the behavioral health unit response in the VIC. Members of the VIC team are a part of the BHST and have specialized training for VIC operations that are not part of the BHST required trainings. Non-licensed behavioral health VIC team members staff the reception desk and serve as greeters. Licensed behavioral health professionals serve as members of the Care Teams. The Care Teams are made up of behavioral health professionals and chaplains trained to assist families in the bereavement process. A family going through the VIC will have the same Care Team throughout the process. The Care Team assists the MO State Highway Patrol (MSHP) with death notifications. The Care Team guides the family through the process including the interview and completion of the Victim Identification Profile (VIP) process, to death notification, answering any questions or concerns along the way.

Items to be funded:

- Full scale exercise of the VIC to include costs of exercise, hotels, staff fees, and travel expenses. **$20,000**
- Development of VIC materials to include two printers, brochures in multiple languages, VIC signage and vests for team members working, and additional supplies as discovered needed during the full scale exercise. **$50,000**

8. Clearly describe the proposed/planned activities utilizing the funds for both FY 2022 and FY 2023 as two separate sections, including an estimated budget for each year. States will be required to report on what activities have been completed using this funding.

FFY 2024 (September 29, 2023 – September 30, 2025) Budget Breakdown

Proposed Activities	Amount
Treatment:	
Services in communities impacted by trauma and mass shootings and recruitment of BHST	$100,000
PCIS	$35,000
FRPN	$7,000
TOTAL:	**$142,000**
Prevention:	
Development of culturally/linguistically appropriate educational materials	$71,124
TeachWell and mass violence	$62,000

Bipartisan Safer Communities Act (BSCA) (P.L. 117-159), 2022
Intended start/end date: September 29, 2023 – September 30, 2025
Amount: $1,088,755

Behavioral Health Crisis & Mental Health Emergency Service promotional materials	$122,375
TOTAL:	**$255,499**
Training:	
Youth/Young Adult Focused Mobile Crisis Response Training	$20,000
VIC team training	$70,000
PREPaRE trainings	$12,000
BHST Member Annual Trauma Training	$105,000
MO BHST Disaster Conference	$150,000
Suicide Prevention Training for Crisis & Mental Health Emergency Providers	$20,000
CISM	$18,900
MO CIT Conference	$73,500
TOTAL:	**$469,400**
Crisis Set Aside (5%):	
Disaster and Crisis Response Liaison, 1.0 FTE	$112,980
TOTAL:	**$112,980**
First Episode Psychosis Set Aside (10%):	
MBHC Position (1.0 FTE) to develop workforce with emphasis on first episode psychosis.	$108,876
TOTAL:	**$108,876**
Total:	**$1,088,755**